

Needle Exchange Networks: The emergence of 'peer-professionals'

A thesis
submitted in fulfilment
of the requirements for the Degree
of

Doctor of Philosophy in Sociology
at the
University of Canterbury

by

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University of Canterbury

2007

Frontpieces

Abstract

This thesis presents a theoretically informed social history of the New Zealand Needle Exchange Programme (NEP) which has operated since 1988. Close attention is paid to how this 'harm reduction' programme demonstrates a pattern of 'peer-professional' hybridity - a form of quasi-professionalism developed by injecting drug user (IDU) peers who began operating private needle exchanges funded by both illicit clients and state agencies. In this hybrid mechanism, the personal distrust required to pursue 'criminal' motivations has been connected, through the vulnerable yet influential intermediaries of peers and syringes, to the trust required to 'empower' the health of marginalised IDU communities. This research has drawn on immersed participant experience and on accounts from archival documents, supported by interviews. A reworking of actor-network methodologies has provided a core analytical approach to tracing the critical moments and boundary-shifts in the development and realignments of the NEP's hybrid heterogeneous assemblages. The assembling and reassembling has entangled policy goals, technologies, historical reviews, stigma, laws, logics, logistic systems, narratives, organisations, sterile and bloody syringes, monitoring systems, and professional occupations. IDU, health policy officials, peer-professionals, managers, politicians, HIV/AIDS community organisers, and medical professionals have prevented HIV transmission by altering key strategic connections and alignments within this active network, while pursuing their public-private interests. The peer-professionals have publicly represented IDU, have advocated professionally for inclusive rather than exclusive public health provisions, while guaranteeing that the monitoring of syringes by state agencies would not harm IDU. The difficulties in shaping and stabilising the NEP have illustrated the 'messy reality' of its institutional and policy environment, yet have also led to highly successful and sustainable health promotion work.

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Acknowledgements

This thesis has emerged from a network of support and contributions.

I wish first to thank all the participants who contributed to this research. In particular, I acknowledge those now dead who worked as peers for their IDU communities through the NEP. From the Christchurch area, Rodger Wright, Wayne Spackman, Chris Neave, Ian Bubbins, Tony Haynes, and Michael J. Hex, are remembered with immense respect.

My networks of IDU friends have provided the key insights that led to creating the name of ‘peer-professional’. Some of these people are still living ‘wild’, others now work in professional fields including health, unions, academia and education. To all of you, particularly Emma, Anthea, Carl, Bryce, Lisa, Jo, Tanya, Peter, Fleur, Tony, Lynne, Chris, Cod, Anton, Hannah, John, Jane, Ros, Pat, Paul, Jude, Doug, Bob, Bodge, Dianne, Terry, Marion, Suzy, Bev, Sheryl, I value immensely your uniquely personal styles of self-expression and your artful resilience in evading forms of unaccountable authority. I hope you will all enjoy this thesis as a non-judgemental reflection on a range of IDU lifeways, and perhaps see a part of yourselves, as modest witnesses to an era, echoed within it.

The contribution of the combined peer groups of New Zealand, expressed at the Needle Exchange New Zealand (NENZ) AGM in 2003, has been invaluable. This thesis has relied on the information provided by many health professionals, particularly the injecting drug users and the peer-professionals who continue to make the NEP so effective. Frank discussions with a range of organisers and policy makers have been crucial for providing a context to documents and for producing a matrix of both peer and professional perspectives. Karen Blacklock, Simon Nimmo, Ian Smith, and Charles Henderson have provided invaluable perspectives on the development and problems of the NEP, particularly as regards NENZ.

The research has also depended on access to archives. The release of the Ministry of Health file on the Needle Exchange Programme has been crucial. The Ministry of Health provided further crucial support by approving my access to archival material deposited by the previous Department of Health. The majority of my source material has depended on such public-spiritedness and commitment to transparency of government. Where I at times draw attention to several instances of a lack of transparency by the Ministry of Health, the general pattern of commitment to transparency and support for independent research must also be borne in mind. Two records administrators, Janine Pickering and Evelina Pereira, made much appreciated special efforts to locate and gain permissions to access hard to find documents.

My choice of supervision by Rosemary Du Plessis and Geoff Fougere has been more than fortunate. These supervisors have been unstinting in encouragement. As the later work proceeded, they have offered invaluable suggestions about the positioning of the analysis and genre of writing within wider academic and institutional fields. Their input has provided an essential orientation in the midst of an intense learning process. Their familiarity with several of my fields, and with the health sector in general, has reassured me that I was not totally off-track when making crucial decisions at turning points, actual or potential, of my research trajectory during this concentrated endeavour.

This research would have been more difficult without the grant of a year's scholarship by the University of Canterbury, for which I am highly appreciative. Various New Zealand government agencies have assisted with my health and other expenses during this period. I especially thank Work and Income New Zealand.

The School of Sociology and Anthropology has provided a collegial atmosphere and frequent seminars in current research which have helped to stimulate my analytical endeavours. I also draw appreciative attention to the seminars offered by the Public Health division of the Christchurch School of Medicine. In being attended by a wide range of consumers and providers of health care, these seminars have provided valuable insights and references to other streams of research.

I am also indebted to many colleagues outside the University, especially Raven for reference checking and organising a protest occupation where I was arrested a month before submission, Barbara Hendry and Jackie James for helping with proof-reading, Lauren and Jodi Irvine for transcribing, Brent Tohiariki for his input about Māori addiction treatment principles, Bill Hager for support when visiting Wellington archives, Hazel Ashton for many discussions on organising communities, Jane Davidson, Nadine Robinson, Debbie Hager, Lis Cotter and Tricesta Engelbretson for constantly encouraging my academic work and their personal example of struggling against difficulties. Fiona Brady and my mother Joyce Emily Luke for many long telephone conversations on the nature of identity and academic work. Without people to listen, as stories tried to emerge, this work would be less accomplished. Without the financial assistance of my father George Macdonald Luke towards research costs, this thesis would have been far less comprehensive.

My sociological training emerged from the case I study here. My involvement with the Christchurch peer needle exchange led to my ongoing support, in a variety of ways, for the Christchurch branch and the National Office of the New Zealand Prostitutes Collective (NZPC). Calum Bennachie, human rights activist, researcher and PUMP (Pride and Unity Among Male Prostitutes) co-ordinator, along with Catherine Healey, the National Co-ordinator of the NZPC and an administrator of the Wellington NEP peer group, have been highly supportive of this research.

Catherine Healey traced several key documents, besides discussing her impressions as a participant in the National Council on AIDS. While networking with this collective in preparation for the political struggle to pass the Prostitution Reform Act, I met five post-graduate sociologists and one visiting geographer from the University of Canterbury. Once having talked about cultural and organisational issues with research sociologists, and observed the difference between their analyses and the mercenary, statistics manipulating social technicians I despised, I soon signed up as an adult undergraduate student with a postgrad research goal in mind. So my deepest thanks to Nicky Green, Peter Eden, Suzanne Phibbs, Maria Perez-y-Perez, Bronwen Lichtenstein, and Michael Brown. And my particular appreciation for Anna Reed. Anna is the first professional prostitute in New Zealand to have been accepted by the High Court as an expert witness on sexwork. Anna also organised the support network where I came into contact with sociology as a research discipline.

I owe my initial academic exposure to historical methods, to the studies of material cultures, and of ritual events, to my undergraduate studies in the Religious Studies Department of the University of Canterbury.¹ The linked concept of ‘dependent origination’ and ‘four-fold negation’ came from studies in Buddhism even before I was exposed to similar concepts through first deconstructive discursive semiotics, then the actor-network strands of Western Sociology. In my first sociology lectures I was taught the critical interplay of social structure, history, and biography. I then entered the Sociology Department’s excellent ‘core theory’ stream of courses, learning methodological aspects of developing interactional boundary analyses in case studies. Hopefully some form of ‘core theory’ nexus will return to the curriculum. I’d like to acknowledge the inspirational vitality and humour of my colleagues during Honours year. Trina Taupo’s work on Māori ethos, Katie Thom’s work on drug using practices, Anton Jenner’s work on treatment regimes, and Jamie Craig’s work on the contentious politics of health sector unions have all encouraged and informed my own work that had its genesis amongst my five honours projects.

I thank all those academics and students who have opposed the development of a corporatist hierarchical unilateral management model at the University of Canterbury. The partly manufactured financial crises and the general staffing insecurity of this period have not been conducive for providing the human and organisational resources and gender equality needed for high quality research.² But without the tenacious resistance, the situation would have been far worse. I mention in particular David Small, Sue Newberry and Colin Goodrich among many

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1. It seems an immense pity, and quite academically shameful, that the areas of Buddhist and Islamic studies lost their lecturers during the period of restructuring in the College of Arts while I was pursuing my research. The restructuring from a more collegiate to a more corporatist, centralised and top-down university model privileged the more positivist disciplines and removed support for the interpretivist specialities, leading to the loss of world-renowned academic researchers and chilling the confidence amongst prospective Religious Studies students.
 2. In particular I refer to cross-disciplinary work amidst ‘belief’ practices, policy interventions, technologies of consciousness, and the frameworks of identity that underpin the academic analysis of cutting edge innovations. I also draw attention to the situation where some academics, particularly in the positivist sciences, have supported a shift to a line management structure, thereby benefiting in the short term, but creating a situation of greater and on-going dependency for those that follow in their departments. This strategy seems to undermine any aspirations for collegial autonomy. It will be interesting to observe the developments of such restructuring.

others. This type of change in my research environment provides a reminder of how the anti-social problems that the university exists to critique by developing its disciplines and its conscience, remain a constant threat within the university itself.

As I approached my final submission date I was arrested in a political protest,³ several weeks before submitting this thesis. Legal conflicts continued through the oral defence phase. Our appeal in the High Court succeeded, helping thereby to reinforce civil liberties and the right to express dissent in public places. My co-defenders, James Abbot and Frances Mountier, have been inspirational. For relieving my mind and time of the need to carry out this legal struggle I cannot overstate my appreciation for the thoroughly professional and pro bono work undertaken by Moana Cole and Mike Knowles, fearless defenders of civil liberties and extraordinary citizens.

Last, but not least, I acknowledge several people who are dead, but who continued to influence me as I carried out this research. These are my maternal grandmother Joyce Emily Knox, who came from Tonga to live in the strange southern lands; Neil Roberts, a punk political percussionist; and Nick, a woman of amazing presence.

This work is dedicated, in random order, to the goddess, crossroads, fearless radical enquiry, local knowledges, ecstasy, the class of emptiness, and universal compassion.

There have been no conflicts of financial, religious, employment or future career interests.

While I have been assisted by many participants, and addressed difficulties of various sorts, any misjudgements or inaccuracies in this thesis are entirely my own responsibility.

The Copyright and Intellectual Property Rights over this Thesis are, except for the images in the Appendices where other ownership is acknowledged, claimed by the author, Stephen Macdonald Luke on behalf of the participants, who expect that full use may be made of this material by anybody for non-profit and academic activities. Normal academic conventions of acknowledgement and citation apply to such usage.

3. I supported a protest against the Christchurch City Council and its public-private partnership with the Isthmus corporation and DownerEDiWorks Construction corporation. This group had been attempting to put a road through City Mall, which is a central city pedestrian area. I helped to occupy part of the mall, along with 11 pupils from the neighbourhood Unlimited School. For a social impact assessment of the City Mall restructuring, see Mackie, Richards, Taylor, & Yangden (2007).

Guide for readers

In general, the University of Canterbury Thesis guidelines, based on APA standards, have been adhered to. For this reason, line spacing is one and a half, and the font is size 11 Times New Roman. Any exceptions to the University of Canterbury guidelines have been consistent. Any grammatical and spelling errors, or clumsy usage, are regretted.

Conventions used:

- I have also used colons to separate in-text reference dates from page numbers.
- Where a date is unknown, or a name is withheld, I use the ‘#’ symbol.
- Single quote marks show that a phrase should be read as a single term, and to emphasise or problematise a single word. Single quotes also indicate material quoted within a quote.
- Quotations are marked by double quotes.
- Legislation and treaties have been italicised.
- At times a meaning that is difficult to convey has been attempted with neologisms.
- I use multiple words joined by a hyphen to indicate a ‘hybrid assemblage’. This usage does not imply that the two words so joined are similar or well-fitting to each other.
- I use a diagonal slash to indicate either equivalence or alternatives, relying on the context or footnotes to clarify the difference.
- I have minimised the use of acronyms, because an acronym inflects the meaning of an organisation it refers to, and because with many acronyms, it is an unnecessary effort for a reader to recall what organisation is being referred to.
- Where I refer to a Minister, Department, or Ministry, without any further specification, I am referring to the Minister of Health, or Department of Health, or Ministry of Health.

My exceptions to the APA guidelines include my extensive rather than minimal use of footnotes. This is because exploratory, single-case studies require thick description, whereas hybrid studies require multiple areas which all need referencing to each other, while historical studies require numerous contextual notes. This material cannot be included in the main body of text if that body is to flow reasonably smoothly, in a readable manner. My solution has been to treat the footnotes as a related ‘chunky’ non-linear text, running parallel and linked to the main body. This is acceptable to me because I do not rely on a dogma of texts being singular and autonomous, yet the footnotes are not as distracting and discontinuous as a hypertext. The meaning of any text is, self-evidently, always a product of an interplay between the environment of the text as a patterned imagination, and the environment of the reader as a moving, pattern-seeking imagination.

Referencing

Due to the large numbers of archival documents, a historical studies type of reference list system has been used. This is based on APA standards. However, the References list has been divided into two sections. The first includes most publicly accessible documents, and some unpublished papers. The second contains archival or private material that would require special permissions to access.

Appendices

A set of appendices offers material that is intended to further assist a reader, but not as part of my thesis argument as minimally and parsimoniously presented, and so has not been placed in the main body of text. This material in the appendices is contextual, relating either to the NEP case, or to conceptual frameworks that relate to the case but are wider and more abstract than my thesis argument can handle and remain readable by most. The appended material includes my University of Canterbury Human Ethics Committee consent, illustrations of NEP educational material, and outlines of several key concepts in terms of wider and long duration sociological concerns. This material conveys a perspective that, in not being intensely focused on my case and its argument structure, can assist a reader in elucidating unclear aspects of the thesis proper. However, the appended material is extraneous and not a part of my thesis argument, which has been honed to a minimal size. The appendices can be completely ignored without detracting from the thesis argument.

Archives

Department of Health Archives	located in National Archives
National Council on AIDS Minutes	located in National Archives
Submissions on amendment to the Misuse of Drugs Act	located in Parliamentary library
Ministry of Health file on the NEP	released under Official Information Act
CIVDURG Archive	not publicly accessible
NECO Archive	not publicly accessible
DIVO Archive	not publicly accessible
WIDE/DHDP Archive	not publicly accessible

Acronyms

ACT UP	AIDS Coalition to Unleash Power.
ADIO	Auckland Drug Information Outreach.
AHB	Area Health Board.
AIDS	Acquired Immune Deficiency Syndrome.
ASMS	Association of Salaried Medical Specialists.
ASN	AIDS Support Network.
ASO	AIDS Service Organisation.
CASONZ	Community AIDS Services Organisations in New Zealand.
CIVDURG	Christchurch Intravenous Drug User Resource Group. (The initial Christchurch peer group).
DHB	District Health Board.
DISC	Drug Injecting Services of Canterbury. (The current peer group that covers the Christchurch area).
DIVO	Dunedin Intravenous Organisation. (The Dunedin peer group).
DHDP	Drugs and Health Development Project. (The Wellington peer group).
DoH	Department of Health. Was disestablished in 1993 and replaced by a Ministry.
ESR	Environmental Science and Research Ltd. (A Crown owned entity).
ESR Health	A division of the ESR.
HBV	Hepatitis B Virus.
HCV	Hepatitis C Virus.
HIV	Human Immunodeficiency Virus.
IDU	Injecting Drug User.
MECA	Multi-Employer Collective Agreement.
MoH	Ministry of Health. This replaced the DoH in 1993.
MOH	Medical Officer of Health.

NECO	Needle Exchange Consumer Organisation. (The IDU group in Christchurch between Nov-Dec 1994).
NENZ	Needle Exchange New Zealand. Founded 1995. A national Trust that represents regional NEP outlets and stakeholders. NENZ co-ordinates research and discussion on any issues of nation-wide scope.
NEP	Needle Exchange Programme. Founded 1987 by means of the Health (Needles and Syringes) Regulations 1987 (later replaced by the Health (Needles and Syringes) Regulations 1998. The sole needle and syringe supply and return programme in New Zealand since 1987. The NEP services are organised around rural sub-programmes, regional urban outlets and national transport services. Co-ordination is provided for through NENZ, NEST, and a Stakeholders' Group.
NEST	Needle Exchange Services Trust. Founded 2001. NEST transports NEP products and wastes, and operates the National Office of the NEP. NEST works very closely with NENZ.
NGO	Non Government Organisation.
NZAF	New Zealand AIDS Foundation. Founded 1985.
NZNO	New Zealand Nurses Organisation.
NZPC	New Zealand Prostitutes Collective.
RHA	Regional Health Authority.
SRHA	Southern Regional Health Authority.
STD	Sexually Transmitted Disease.

Preamble: Bio-genesis

“I believe that it is essential for everyone to have a goal in life ... Whether the goal is ever attained is not important. It is the satisfaction we achieve from striving for it which I believe is the point to life without anything to aim for, life would be extremely dull, regardless of the ultimate reason for our existence, therefore, is it not better to make that existence satisfying? It is entirely up to the individual
“(Robert David Muldoon, (New Zealand Prime Minister 1974-1984), pers. corr. 1980).

As a youth in the seventies, I experimented with 'mild' illicit drugs. Yet I was not especially intrigued by law breaking or law making until I was strangled unconscious by four New Zealand policemen during an anti-apartheid protest in Auckland.⁴ When I complained about the incident to police authorities, they declared it had never happened. It did not appear in any record.⁵ This experience triggered an abiding interest in links between injury, illness, reliability of official records, law enforcement, resistance, protest, and politics.

After developing epilepsy during the 1980s, possibly due to the strangling incident, I had experiences of a medicalised type of stigma and 'mis-fitting'. Epileptic seizures can resemble drug experiences such as nitrous oxide, or an orgasm without sexual arousal. At times, reflecting on my situation, I compared drug use with the hallucinatory and mood-altering aspects of a seizure. The mind alteration of epilepsy could be considered either meaningless or informative, 'mad', or 'bad', since when similar changes are achieved through drugs, the mind alteration is supposedly very mad and bad.⁶ Epileptics are always aware that they might abruptly have to lie down, perhaps in public place, vulnerable to the hazards of being perceived as deviant, not only from strangers but more worryingly, from friends who might treat one differently. So, although my rate and type of drug use did not increase, my awareness of stigma as a sibling of 'sickness' certainly did.

I was initially intrigued by, but not a member of the IV League. However, several injecting drug user (IDU)⁷ friends were members. When they started an after-hours, peer-run needle exchange called the Christchurch Intravenous Drug Users Resource Group (CIVDURG), I volunteered to help, and became a licensed syringe supplier,⁸ and was voted onto the Trust Board within six months. I had not injected drugs for several years, not because of withdrawing, but because my use of anything except alcohol has always been experimental and reflective.⁹ In 1990 I learnt I had acquired hepatitis C. Hepatitis C is a silent, deviant, and devious disease.¹⁰ It is mostly acquired

4. I was left unconscious in a service space behind an anti-apartheid protest. The protest was part of the anti-apartheid disinvestment campaign aimed at New Zealand Insurance and South British Insurance corporations.

5. It was not 'a fact'. It had no number. It did not count. But it had an effect.

6. For an introduction to 'pharmacopia' as mixing both illicit and licit substances, and as liminal substances, and as mediating public and private conduct, see Persson (2004).

7. IDU is used as both singular and plural, both a noun and an adjective. It can refer to a category or population of IDU, or to a specific group of several or more individual IDUs. This range of use is also found in policy and academic writing.

8. See Registration approval in Appendix 2.

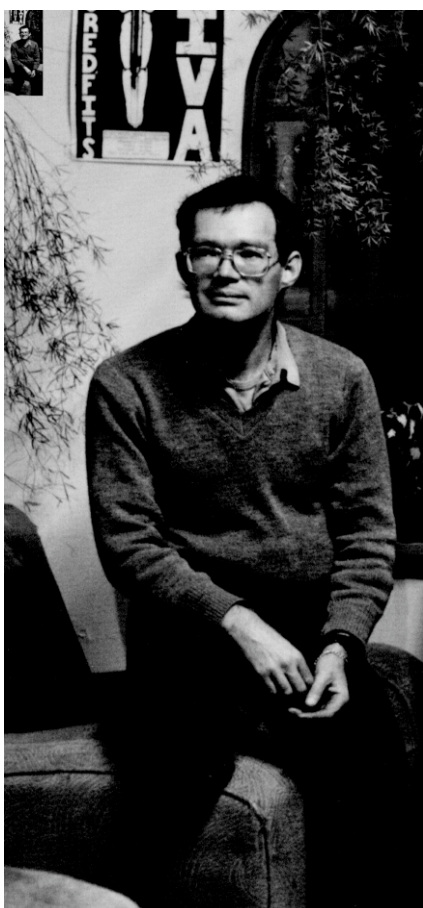
9. I enjoyed the illegality and transgressive aspects of injecting. However, I preferred hallucinogens, which didn't need to be injected to be fully effective, and I had no intention of becoming dependent.

10. The New Zealand government delayed testing the national blood supply from 1990 to 1992, causing many haemophiliacs to acquire Hepatitis C. No explanation has ever been offered, showing how well-evidenced mistrust and silence has surrounded HCV transmission and prevalence.

through blood transfusions from an unscreened supply, or from the sharing of syringes and other unsafe injecting practices.

The key founding members of CIVDURG had been members of the Christchurch Unemployed Rights Centre, and most were members of an anarchist¹¹ role-playing network. We knew and trusted each other in a different, parallel type of group network, outside of the exchange. This aspect was more important than I had realised at the time, with the first two years now seeming comparatively harmonious and functional compared with later years. I initially enjoyed working at the exchange. It was fulfilling to work with like-minded people in a progressive social experiment. It seemed a general step towards treating drug problems primarily as health problems, rather than crime or moral problems, while helping to address some of the immediate health concerns that I saw around me.

Picture 1: Myself, while working at CIVDURG in 1989



(Photo from personal records)

However, the environment felt uncertain, and we worried that the authorities might alter their policies and disestablish us. After a year, our work felt somewhat more 'normal'. During this time I began writing a training manual, but found that IDU experiences, in the work environment of a needle exchange, could not easily be formalised. Much of what we did involved formal record-keeping as required by our funding contracts. Nevertheless much more of the networking around peer health and representation was highly informal, and the meaning of these connections were difficult to record, especially in terms of peer understandings. Since we had little access to the records of other exchanges, and since we were not well-informed of policy considerations by our funding agencies, we could not easily analyse patterns. We soon drifted into a state of pragmatic, theoretical, and political forms of dependency on the output requirements that were specified in our funding contracts.

11. The anarchists associated with the Christchurch NEP were primarily individualists. There are many types of anarchism, including academic and libertarian communist. Most types promote the ground-up development of organisational forms where any authority is as directly as possible accountable to those affected by the exercise of that authority. There is a clear intersection here with research ethics. In a sense, anarchism is similar to a semi-spontaneous religious movement, without deities or dogma, but with embodied ethics, intense commitment, and a highly distributed congregation. For a history of anarchism in Aotearoa/New Zealand, see Boraman (2007). For current theoretical work about anarchism written from New Zealand as a locality see Torrance (2007a, 2007b).

This situation was not helped by the seemingly constant dissolution and new emergences of agencies in the health sector environment, within which these funding agencies hovered between existence and non-existence, along with their outputs, and along with the outcomes of the NEP.

The co-ordinator of CIVDURG seemed indispensable as an organisational focal point, and attempted to do everything herself. No other models for group work were available, which meant that the training for IDU 'peers' became a concept which resisted formal prescription. The co-ordinator, however, developed private skills in translating between the worlds of health professionals and peers. These different moral frameworks and legitimations became woven together with the commercial transport web of syringe sales, disposal of used syringes, and accounting procedures.

As our systems in CIVDURG became more formalised, a pattern of problems became apparent. The financial constraints made it difficult to try anything new. This created a fatalistic and negative atmosphere. We couldn't easily evaluate ourselves because we were structurally isolated from the other peer groups we might have been able to compare ourselves with. We were also finding out how a small community¹² organisation actually worked. It became apparent that greater analytical and managerial skills needed to be distributed across greater numbers of people to provide flexibility and capabilities for expansion. These skills were being sourced by the co-ordinator on a personal basis from other organisations, such as drug treatment clinics and AIDS service organisations, which held different interests and accountabilities. I, and several other CIVDURG trustees, found the consequent unaccountability and the uncontrolled dependency on external expertise to be unsustainable and unacceptable. Our desire for enhancing the professional standards and resources within the Trust led to systemic conflicts within the Board on which the co-ordinator sat, and which employed her. In 1992, due to these conflicts, I left CIVDURG.

In late-1994 I was invited by a large group of IDUs to help restore CIVDURG, which had collapsed both legally and financially over the preceding two years. Apart from the co-ordinator, only one Trustee was evident, though several existed on paper. A recently employed administrative assistant was keeping the office functioning, but no governance activities were being arranged by the co-ordinator or the Trust Board, which was not meeting and could not obtain a quorum. No IDUs, nor health professionals, were willing to become trustees while the co-ordinator remained in charge. The IDUs who wished to revitalise CIVDURG had concluded that merely glossing over the systemic problems would risk the local services becoming run by those unfriendly to IDU and could conceivably threaten the overall NEP. It would also expose prospective trustees to legal hazards, since the Trust had been without a quorum for over a year and had ceased to be a legal

12. I consider a community, in an analytic sense, to be a group which is represented by its members defining themselves and their boundaries as 'self-perpetuating through an internal infrastructure of care'. This definition largely overlaps with the conventional definition of the majority, or the mainstream. Nevertheless, these definitions are quite different, since the latter is based on comparative numbers, whereas the former is based on relationships.

employer, despite employing a highly respected person from the IDU community as an office worker. Accordingly, surgery seemed indicated.

During a tense, uncertain month this group of IDU established legal and day-to-day control over the exchange. We named ourselves the Needle Exchange Consumer Organisation (NECO). NECO ran the exchange for several months in partnership with the New Zealand AIDS Foundation (NZAF). The NZAF negotiated a short-term contract with the Southern Regional Health Authority, which had been the previous funders. Our group then became subsumed into a 'new model exchange' called the Drug Injecting Services of Canterbury (DISC) Trust. The DISC Trust Board was dominated by health and AIDS Service Organisation (ASO) professionals, yet included a substantial representation of IDU clients and peer workers. The new model was also supported by state funding authorities, the NZAF, the New Zealand Prostitutes Collective (NZPC), and local medical practitioners.

After a year working as a DISC volunteer I decided that some aspects of the exchange were far better, while others had not changed so much, but were not as dangerous as previously. Yet, I felt neither a peer nor a professional. My experiences and perspectives were not conveniently 'whole'. I felt 'out of place' in the new structural roles. I asked myself 'Was I an IDU peer?' The past co-ordinator had claimed I wasn't, since I didn't have a habit. I agreed, in terms of representing drug-dependent IDU, but felt this attitude undermined NEP health outcomes, since I did have HCV, most likely from recreational injecting. There seemed a conflict between the health benefits for drug-dependent IDU, and the general IDU benefits of reduced risk from blood-borne diseases (BBDs). I also didn't like some aspects of the new Trust Board. There was a distinctly patronising feeling hovering about of 'now that the experts are finally in charge, those incompetent junkies had better not cause any more problems'. I felt that some more 'established' people were alarmed that IDU had briefly taken control, since we had shown how the functioning of the exchange depended not only on the complex arrangement of state funding and links with other AIDS Service Organisations, but also on the goodwill of IDU and their implicit agreement not to organise alternative forms of service provision.

It was distressing to feel a partially arrogant edge to the professional power emerging from the new arrangements. This seemed as potentially harmful as had the previous co-ordinator's stance, only from the other side of the professional divide from IDU. I wondered whether the benefits of financial health and reputation were worth the cost in IDU autonomy ... and had to answer yes, considering the previous shambles which had jeopardised so many people's health. The problems had emerged from an IDU autonomy which had not professionalised except in name, had then become frozen as a 'petit hierarchy', then had drifted into isolation, away from supportive links with AIDS Service Organisations and regional health agencies. The old system had been open to abuse, which had led to rigidity and collapse, yet the new system created narrowed accountabilities

and dependencies in more structured ways. Representation and trust felt more connected, yet also somewhat erratic, with a machine-like rhythm and alien flavour. I felt accountable, just as all peer-professionals in needle exchanges are accountable to the community they represent and work with, yet also gather information for the state agencies which increasingly fund them.

Holding these motivations and knowledges, I approached this research gingerly. I wanted to understand my experiences better, yet also to understand how the whole area seemed inherently troubled while also feeling as if accomplishing something genuine and solid. Social life has generally appeared to me as a game behind a game, where the obvious set of rules and players disguised a different set, so that well-meaning activity merely played into the strategies of well-connected elite networks. It struck me as a participant that despite such tendencies, the NEP has been genuinely original, offering a unique type of value through a very simple yet absolutely necessary service in providing syringes. I am even more firmly convinced of the NEP's originality after studying its history and institutional shaping. Yet the NEP has proved very different from my expectations in other ways. It suggests that social life is more complex, yet also more raw-edged and open to change than a simplistic model of 'rules within rules' would suggest. I found controlled forms of health co-existing with unpredictable possibilities of desire and risk. These forms of loosening and solidifying activity cross our human, object, viral, organisational, and institutional boundaries, but not in a very predictable way. The value and principles of the NEP clearly inform the heterogeneous interactivities that constitute many other fields.

Section 1

Introduction: Contexts, Sources & Theoretical Framings

Strange - yet so strangely fitting

“to set free, in the delirium, this creation of a health or this invention of a people, that is, a possibility of life”

(*Essays Critical & Clinical*. Gilles Deleuze, 1997: 4)

1 Needle exchanges: A dynamically networked environment

Late in 1987, the New Zealand Labour Government reluctantly authorised a single national Needle Exchange Programme (NEP). The consequent legislation attracted bipartisan support in parliament and was explained in terms of an urgent public need. The NEP was to provide the range of services required for supplying sterile syringes to illicit drug users, to promote greater safety in the injecting and sexual practices of injecting drug users (IDU), and to collect used syringes for safe disposal. IDU are private people. They have strong aversions to being publicly labelled as IDU. Nonetheless, IDU were to regularly visit these public sites where they would be monitored and recorded on behalf of state agencies. This type of risk, met by this type of trust, seems strange in competent 'criminals'.¹ It was strange enough in 1987, yet even stranger in 2007 after successive parliaments have increased the penalties and difficulties for illicit drug use. Even more perplexing, IDU have regularly been held in custody and charged with possession of the licit syringes they have purchased or exchanged at the NEP.² In 2007, IDU continue to obtain sterile syringes, to purchase laboratory-grade filter units, and to return used syringes to approximately 180 registered, street-front outlets for disposal.

One might query my choice of needle exchanges and IDU peers as being appropriate objects for the study of policies and organisations. Is not the NEP an aberration and, as with its drug injecting clients, of no account, indeed abominable, in the orderly and moral scheme of things? Yet even if the grand scheme of things was in fact the ultimate destination, studying the NEP's emergence and development as a unique event seems useful as a way to explore New Zealand's neo-liberal policy environment as a not so grand narrative exploration. The NEP offers a case study of some actual practices that have influenced the environment and field of health care. For twenty years the NEP has relied upon its close associations with criminal IDU activities and communities, yet has also depended upon state funding for its educational materials, labour costs, administration overheads, and charges for disposing of returned syringes. Furthermore, the NEP's professional standards of health care for IDU developed without concerted opposition from the same health professions that

1. Here drug users are referred to as 'criminals' because they intend to commit what they acknowledge as a technical crime of possessing illicit drugs and paraphernalia, particularly syringes, for the purpose of injection. Such IDU have not necessarily been caught and convicted of any crime. IDU may romanticise their activities as alien or exotic, but in general, approve of and normalise their illicit injecting activities. IDU are reasonably aware of the import and risk of such activities. In terms of agency they are 'criminals by intent', not "zombies" (Valentine, 2007: 504).
2. See Arrest Referral Scheme (2005: 3), Appendix 3, and discussed in more detail in chapter 12.

claimed a jurisdiction over diagnosing and treating IDU motivations and behaviour. The silence of the professions is intriguing, since professions in general are in part characterised by their claims over occupational territory and their theoretical expertise. This silence draws attention to the way conventional professional aspirations have been echoed and developed into the strange many-angled shapes of the NEP.

According to an authoritative 1996 account, between 1986 and the early 1990s the public urgency over HIV/AIDS was addressed by a “three-way partnership between the government and medical and the community health sectors” (Davis & Lichtenstein, 1996a: 5). The NEP was founded towards the end of this period. The three-way partnership has been presented as being characteristic of New Zealand as well as the global best practices of health care, but also as having receded into a “decline of the partnership model [and] ... complacency” (Davis & Lichtenstein, 1996b: 226).

In an earlier 1994 account, Plumridge & Chetwynd write of HIV/AIDS policy as being a constructed consensus, “dense with contradiction” (1994: 294). This account better matches the archival documents I retrieved than does the Davis & Lichtenstein account of the vague national emergence of a consensus partnership. But the Plumridge & Chetwynd account does not describe how consensus and contradiction came to coexist in policy and practice.

I found that the archival record of institutional antagonisms, seemingly forgotten, offers a route to an empirically detailed account. My account describes in empirical detail a specific mechanism involving an alliance of contradictory interests through which the NEP was founded and shaped. Furthermore, since both the actuality and model of ‘partnership’ have been authoritatively presented as having collapsed, explanations based primarily on partnership and consensus models have correspondingly weakened. To be strengthened, such explanations requiring alternative or additional causal entities and wider contextual frameworks. In the account offered in this thesis, the partial stability and overall sustainability of the NEP is explained by its mechanism of hybridity.

In this research I explore the on-going capabilities of the NEP in terms of its founding conditions and the subsequent ways by which it has modified its environment. I pay attention to the NEP’s boundaries of practice, to its conditions of possibility, and to how its constituent elements have been closely connected. These closures, together with wide connectivity at national and global scales, make this analysis an institutional and organisational study in social science, rather than simply a social history, or a cultural evaluation, or an examination of a policy intervention.

My account is informed by actor-network³ approaches, described elsewhere in this and the two following chapters. Actor network approaches favour detailed case-studies that pay attention to objects. The approach encourages an even-handed analysis focused on asking ‘how’ things happen,

3. For a related topic and a related articulation of actor-network with historical and governance approaches to analysis, see Valentine (2007: 498-499, 510-512). See also Appendix 9, particularly 9.4.

rather than ‘why’ they did, or should, or should not happen. My version of an actor-network approach involved a wide focus and deep inspection of ‘activities’, particularly movements and motivations that only made sense in terms of each other. I explored the movements and motivating forces involved in the interactions of syringes, legislation, specific organisations, advisory committees, and three professions, namely pharmacy, medicine, and drug/addiction treatment. By describing the interactions of such constituents, I explicate the NEP case, and supplement a partnership model with a hybrid model involving health work with criminal communities in the ‘wild’ (Callon & Rabeharisoa, 2003).

Various governments and polities have created a range of needle exchange systems in similar attempts to control the drug-using desires, risky hypodermic technology, and the blood-borne viruses which in combination have resisted conventional forms of control. Despite being partly influenced by global concepts such as ‘harm reduction’⁴ the New Zealand NEP differs from those found in other countries. For one thing, it has retained a significant degree of community control by the representatives of its IDU clients. This is most unlike many other programmes of community empowerment that responded to AIDS.

The NEP was founded with an intent to prevent the sexual transmission of HIV from IDU into ‘the community’. This ‘community’ had excluded IDU through forms of medicalising, criminalising, and stigmatising. Nonetheless, the NEP attempted to include and empower those defined as illegal. This seems an abnormal form of targeted health care. Yet the NEP also developed as a pragmatic application of the harm reduction and community empowerment principles that were also being expressed globally in the form of the Ottawa Charter (World Health Organisation, 1986). The foremost planners of the NEP specifically contrasted the principle of ‘harm reduction’ with the abstinence and prohibition goals associated with the principles of ‘harm prevention’⁵ (Lungley & Baker, 1990: 79) and ‘harm elimination’⁶.

4. Described elsewhere in this chapter, in Chapter 3, and Appendix 8.

5. A New Zealand Coroners Court has produced a useful definition of harm prevention, illustrative in its black and white, binary, determinist logics and language. Instead of pragmatic common sense, the following statement offers a revealing example of ideologically formalised common sense. The Court pronounced that: “It is elementary that all conditions apparent to the senses are the phenomenal effects of preceding causes. If one changes the causes one automatically changes the nature of the effects. Thistle seeds may no more produce a crop of grapes than grapeseed may produce thistles. Harm minimisation is directed to mitigation of causal effects. It is akin, in medical terms, to treating a patient symptomatically. The cause continues to produce effects. How does one bring about change at causal level? It is the Court’s view, on the evidence before it, that the primary principle in drug education programmes for children and young persons must be harm prevention. Harm reduction strategies must be supplementary to the primary purpose. The proper approach to be taken in a therapeutic interventional context is the prerogative of the treating clinician. Quite obviously, the factors that protect against the development of substance use and abuse are the polar opposites of those negative factors enumerated in para[14] hereof, predisposing to the development of dysfunctional individual and family units” (Coroners Court, 2005: 46). This Court advocated that more funding be found for preventative education, but ignored the problems of monitoring, the availability or not of evidence for effectiveness, and the risk of capture of such funding by a drugs treatment industry with an ever-expanding clientele. The Court was able to ignore such pragmatic difficulties by appealing to a binary logic, and an essentialist ideology, presented in religious metaphors of good and bad vegetation, of prohibiting risk and trying to enforce safety, no matter the cost in terms of efficacy and social resources.

The labelling of policies intended to address harm and risk can be very confusing. Without close analysis of the methods and assumptions actually associated with the terms in the same document, it can be difficult to know what is meant or imputed in any particular usage, since harm minimising and harm reduction are often differently understood, misleading in intention, and ambiguously deployed. Miller (2001) considers that although increasingly used, the principles of harm minimising and harm reduction have not been subjected to adequate sociological scrutiny and seem an extension of 'surveillance medicine'. The Royal New Zealand College of General Practitioners (RNZCGP) has described harm reduction practices as the acceptance of drug using as a fact while focusing on reducing harm for as long as drug use continues.⁷ Harm reduction entails a pragmatic acceptance that using substances for recreation and performance is a universal human practice. The description acknowledges the dignity and human rights of drug users by framing their choice to inject drugs as a fact, rather than a value on cultural scales of legality, of good/evil, and of status/stigma.⁸ The RNZCGP focus on 'actual harm' prioritises research methods that depend upon actual empirical evidence.

New Zealand's 'harm minimisation' policies⁹ have also been evidence-based. However, some differences between reducing and minimising practices are notable, for instance in a definition from Occupational Safety and Health (OSH) (2005). OSH is a New Zealand Government agency that has defined 'harm minimisation' as: "an approach that aims to minimise the adverse health, social and economic consequences of drug use, without necessarily ending such use for people who cannot be expected to stop their drug using immediately" (Occupational Safety and Health, 2005).

Whereas the RNZCGP definition of harm reduction referred to people 'unwilling to give up' their drug use, the OSH definition of harm minimisation referred to people who could not be 'expected to stop' their drug use. The assumed agency of IDU is presented differently. In the RNZCGP version of 'harm reduction', people are credited, in their "being unwilling", with the ability and right to make their own decisions, despite potential hazards which would require reduction. The

6. Harm prevention involves taking a criminological approach to social and individual health problems. Harm elimination involves a totalising approach to harm prevention, such as population-wide drug testing, attempted manipulation of cultural identity on a mass scale, and other assaults on civil liberties.
7. This definition is offered by Riley (1999, cited in The Royal New Zealand College of General Practitioners, 2005): "The essence of harm reduction is embodied in the following statement: "If a person is not willing to give up his or her drug use, we should assist them in reducing harm to himself or herself and other"" (Royal New Zealand College of General Practitioners, 2005).
8. Harm reduction approaches provide a range of individual goals, specific to a particular cultural environment, in order that the unique combination of factors in an individual's drug using life-world are not reduced into a single systemic category. Moore has pointed out, using an actor-network type of analysis, how the reconfiguration of particular activities of named substances, such as heroin, into a general category of 'drugs', have altered the legal and health consequences for heroin users and treatment specialists (2004). Moore examined how a dogmatic policy response of eliminating all illicit drugs excluded the capability to provide evidence-based treatment services for users of a particular drug in particular circumstances.
9. The *National Drug Policy* adopted by the New Zealand government in 1998 was described as a harm minimisation policy (Ministry of Health, 1998a). This policy and its successor introduced in 2007 are interesting since they seem to include harm reduction as one of the three primary constituents, alongside drug supply reduction and demand reduction through education and deterrence. However, in this harm minimisation policy, harm reduction seems renamed as a new policy called 'problem limitation'. This 'problem' to be limited seems much less evidence-based

OSH version of 'harm minimising' positions people as lacking the control to make decisions which comply with social ideals and the expectations forced upon them. The delicate differences in these particular usages are not specified in their context of use. The OSH site, which represents official health perspectives, does not mention 'harm reduction', and the RNZCGP site, which represents a subset of professional health perspectives, does not mention 'harm minimising'.

The 'harm minimisation' principles expressed in New Zealand's *National Drug Policy* after 1997 include and valorise drug prohibition legislation (New Zealand Government, 2004, 1998, 1975). The requirements to be directed by international legislation and social order¹⁰ take precedence over being directed by an empirical evidence base. The *National Drug Policy* has also replaced the harm reduction approach of empowerment, of better immediate health, and of motivation change, with a disempowering treatment approach that favours abstinence and stigmatises unwilling patients.

In 2005 the Associate Minister of Health, Mr Anderton, outlined how the:

National Drug Policy seeks to strike a balanced approach to minimising drug-related harm in three ways: law enforcement aimed at reducing the supply of drugs; education and community resources to reduce the demand for drugs; adequate provision of Government-funded treatment services to reduce the harm caused by drugs to individuals, families and communities.

(Coroners Court, 2005: 65)

The most ground-breaking change in the twenty year history of the NEP came about in 2004 with the introduction of a government-funded, free, one-for-one syringe exchange system. Yet as a corollary of its increased government funding in the free-one-for-one scheme, the NEP has become more vulnerable to assimilation into conventional or other treatment services. These services would have experienced greater difficulties working with a primarily user-pays, client-driven commercial logistic of supplying syringes. Nonetheless, financial logics aside, the health care logics of 'treatment' in more tightly controlled systems were already supplanting at least some of the logics of 'open', client-led, harm reduction systems.¹¹ In addition, significant difficulties involving conflicting 'logics of distrust' have remained from the NEP's founding era.

In 1987, the harm reduction and community empowerment approaches were required because IDU did not normally comply with directives from health professionals and officials, and worked to

and more social, or cultural and perhaps moralistic, than the term 'harm'. It is a vague area. The *National Drug Policy* is somewhat influenced by the Minister of Health. An amendment in 2000 to the *Misuse of Drugs Act* created the Expert Advisory Committee on Drugs (EACD) as a Ministerial advisory body. The EACD provides 'independent' scientific and medical expertise and evidence on drug issues, generally already defined as social problems in political forums. The record of EACD decisions, for instance the restricting of NOS (nitrous oxide) in 2006 and the banning of BZP, a moderate stimulant, in 2007, suggests that evidence-based policies of reducing or minimising harm increase the influence of health professionals over public perceptions of the use of various drugs, rather than the public providing a body of evidence that directs EACD members in their decisions. Furthermore, the EACD is specifically accountable for evaluating the harms of drug use, and is not specifically empowered to evaluate any benefits, but does so when this does not conflict with prior defining of social problems.

10. Judges are well known for preaching ideological sermons on the seemingly universal 'evils of drug use' when convicting IDU. In the mid-1980s, several influential medical professionals who wrote to the Minister of Health about AIDS used language with similar religious connotations.
11. As also illustrated by the ambiguous role of 'harm reduction' in the framing of the *National Drug Policy*. See Ministry of Health (2007, 2006b, 1998a), New Zealand Government (2004, 1998).

evade legal requirements. Nonetheless, the NEP attempted to provide a professional quality of care, by promoting preventative health through motivation change and safer environments, in ways acceptable within the cultural worlds of injecting, across the whole of New Zealand's population and urban centres. Yet in achieving this goal, the resultant organisation became a more solid, fixed target for more government control and surveillance than could be applied directly to IDU.

In 1985, Bruce Burnett, a gay community organiser, was the first to publicly advocate for a harm reduction approach that promoted a safer-injecting programme for IDU. In the same year Burnett also co-founded the New Zealand AIDS Foundation (NZAF). The NZAF directly and publicly promoted safer injecting, and consolidated the harm reduction concepts that later were incorporated into the NEP. A second organisational path to the NEP was provided by a small number of pharmacists, such as Mr Pollard in Christchurch, who supplied syringes illicitly, in defiance of their professional body. Although never convicted, Bruce Burnett and these pharmacists were 'criminals by intent'. They directly helped gays and IDU to bypass legal prohibitions on gay sex and syringe supply respectively, while also advocating for legislative changes to make the law-breaking unnecessary and the practices safer. Yet, both Burnett and the dissident pharmacists were 'professional', and both conveyed their initially unwelcome messages to policy forums in direct actions that could not be ignored. These actions 'exchanged' public health for public order.

The development of different types of 'exchange activities' have been important to everyday users of the NEP. In 1987 the NEP was planned as a user-pays system where a single ten-pack of syringes was sold for cash. This practice rapidly developed into selling single syringes for cash, counter to NEP regulations, then eventually developed into a state-funded, free, one-for-one exchange system in 2004. The terminology and understandings of 'exchange' that I found in accounts increasingly unfolded layers of complexity and connectivity in how they have worked and developed. I began to see how IDU activities altered in their public and official representation by the way certain IDU participated as peer personnel in the NEP. I also saw how syringes became less of a health problem and more informational, developing into a measure of the NEP's health services, while remaining deviant and difficult to regulate by officials responsible for overseeing the NEP. Such concepts provided new research perspectives. The multiple aspects and distributed entanglements of the NEP meant that while it has been a single programme, it has not formed as an unambiguous, single case. To describe the characteristics and capabilities of the NEP as a whole, I focus on a specific hybrid feature of the NEP which I term 'peer-professionalism'.

The term 'peer-professional' does not (necessarily) refer to the significant amount of problematic alcohol and other drug use by doctors (Robinson, 1998). By 'peers' I mean people who share and respect their mutual backgrounds, knowledges, and interests. In this case I refer specifically to knowledge about injecting drugs, and to people who acknowledged themselves as criminals by

their mutual intent to partake in illicit activities. The people were mostly IDU, but also included small numbers of treatment specialists and pharmacists who sympathised with IDU while overlooking or facilitating illicit activities. There are many different 'types' of IDU, of different age cohorts, in different phases of their 'drug using careers', with different ethnicity and gender, and preferring different drugs. Despite such differences, IDU share a mutual problem of being legally defined as a single type of deviant (Moore, 2004). IDU peers are also joined by their experiences of injection, and by the logics and stigma attached to the technology of syringes. For instance, a syringe must be 'manipulated' with skill, 'co-ordinated', and 'positioned' in 'appropriate' places. Its symbolic meanings must be 'managed' when referred to in 'collaboration' with other IDU. A syringe is constantly active, in its object-hood, in defining its owner and the owner's relationships with others. A syringe motivates its user, as well as being used in motivated ways. Drugs, syringes, and peers combine to constitute IDU practices. Yet this relational network borders on and connects, despite barriers, to conventional professional practices.

I have used the term 'professional' in two¹² conventional senses. One use refers to qualified people organising into formal occupational groups based on exclusive expertise and a collective loyalty that is recognised by special dispensations offered by governments and state agencies.¹³

Professional autonomy is generally valued because of the essential nature of the services, their reliability, and an ethos of public interest. Such professionals regulate essential services in collegiate rather than bureaucratic, autocratic, market monopoly, or open market methods. Another use of 'professional' refers to claims of expertise and accountability by unqualified people and services that are presented as 'of professional quality'. This usage may be applied to official duties and market activities where there is no long-term duty of maintaining a social institution, or a professional body, or public trust.¹⁴

I use the term 'peer-professional' to refer to a specific pattern of connections, or configuration,¹⁵ between several types of hybrid relationships. One relationship involves the joining of the broad goals of crime prevention and health promotion. A second relationship joins the specific goal of

12. There might also be a third type of professionalising involving two sets of specialists that each accredit the other with being professional, yet outside of any public engagement and requirements for trust. Such professionalism could conceivably emerge within a larger hierarchal system or any private, non-market system.
13. For discussion of professions see Abbott (1992a, 1988: 161), Freidson (2001, 1999, 1994, 1990, 1984, 1975), Bucher (1988), Immergut (1992), Larson (1977), Johnson (1972), Bucher & Strauss (1961), Hall (1949), Durkheim (1957). For discussion on discretionary work practices outside of major state sheltered professions, in European contexts, see Le Bianic (2003), Evetts (2003), Tordoier (1995), Habenstein (1970), Elston (1991: 59), Döhler (1989), Reiter ([undated]). For a theoretically informed outline of changes in New Zealand health professionalism see Tully & Mortlock (1999).
14. See for instance Greene (2004) on pharmaceutical salespersons who do not interact or establish trust with the public, but do employ a tactic of mimicing genuine health professionalism in order to more effectively influence their doctor clients.
15. By configuration I mean the whole shape of the connections of a system of multiple constituents. This is related but different in perspective from the way I use the term 'articulation' to mean a following of a linear strand in a configuration. Because writing and speech are linear, their grammatical expression of systemic meaning tends to be 'articulated'. But when drawing on topological expressions and metaphors, configuration seems a more appropriate term. Often these terms are equivalent, but not when causation or temporal sequences are significant.

promoting safer material environments by providing syringes, to the goal of shifting IDU motivations towards greater control of personal and public health. The latter relationship links the commercial methods of supplying syringes with the trust needed to influence motivation change. My use of the term ‘peer-professional’ refers to the public face of drug use, combined with professional standards of work and professional aspirations for autonomy and public trust.

My terminology of ‘peer-professionalism’ does not refer to professionals who become drug users, nor to ex-users who have trained as counselling professionals. This is because such people are not publicly presented as supportive of practising IDU nor of representing the collegiate knowledge of on-going developments in illicit injecting practices. Nor is any professional training and qualification implied by my term of ‘peer-professionalism’ so long as professional types of goals, logics, and practices are being pursued.

The term ‘peer-professional’ emphasises a deliberate and necessary, yet also uneasy and ambiguous, linking of criminal drug worlds to professional health worlds. My analysis pays attention to the peer and professional aspects of how these two goals combined to align materials, expertise, reliability, and evaluative components in an interactive system of sites and linkages.

Although initially exceptional, needle exchanges were achieved through normal methods which seem patterned as well as aberrant. I will describe in following chapters how the initial shaping of the NEP was reinforced or adapted by means of stable¹⁶ practices, trials of strength and trust, and normal everyday luck, into patterns of greater sustainability.¹⁷ These regular practices and presumably random chances formed a relatively consistent environment. I draw attention to the way my most significant explanations derive from both the structural and eventful character of the mechanisms of activity and capabilities that configure this environment. I also emphasise the networking of linkages, gaps, barriers, and circulations that constituted this environment.

My research initially focused on the capabilities that emerged from the changing relationships and the exchanges of territory and influences between the drug injector networks, health officials, medical professionals, and peer educators who founded and developed the New Zealand NEP. My approach has ‘drawn’ a range of key stories, both historical and structural, into an interlinking account of a single case. This has been more an assembly than an integration since I did not assume that the case started as singularly integrated. Instead I looked for linkages and good fit while working ‘outward’. As a result of this process I invite attention to how the boundaries of the NEP’s institutional activity as ‘work’ can be understood, along with its capabilities. By building on, re-specifying, and offering a ‘mechanism of action’ for previous accounts, I can explain the NEP’s record of sustainability by describing its characteristic founding ‘problematism’ of altering the

16. By stable I mean patterns that are not expected to change rapidly, unlike trials and conflicts where abrupt change would not be surprising.

17. By sustainability I mean neither stability nor change, but survival through times of rigidity or uncertainty.

motivations experienced by a marginalised ‘community of crime’. Unlike homosexual practices and soliciting, which came to be decriminalised, injecting drug use was not decriminalised, nor regulated, nor ignored. Instead, some of the drugs often injected became more criminalised and none became less illegal. The antagonisms between crime systems and health systems, by becoming entangled yet remaining distinctive, contributed to a troublesome hybrid arrangement responsible for the more significant of the NEP’s capabilities. An account of peer-professionalism links the NEP with IDU, with a specific new occupation, with a form of peer representation, with professional health aspirations by non-qualified persons, and with professional standards of commerce in syringes and other drug-using paraphernalia. I will argue in chapters 10 and 11 that this peer-professional pattern explains crucial aspects of the NEP’s beginnings, shapings, stability, and sustainability.

2 Sketching a route: An index of landmarks

When planning an exploration of new territory it seems useful to lay out what is generally known, before problematising, extending, and triangulating from a range of different perspectives. In this section I present the bare necessities of quantitative and chronological case information. This outlines the scope, type, amount, and rate of change of IDU and NEP activity, stripped of the significance and unpredictability presented in following chapters.

The use of chemical substances in New Zealand has been variable, at times seemingly non-existent and at times intense, yet generally absent from historical records. The written information available about indigenous Māori cultures¹⁸ does not tell of psychoactive substances being used in practices presented as recreational, dependent, or deviant. After the first exploratory contacts and negotiations led to settlements of Europeans, increasingly from the UK, the visitors and colonists used quantities of various drugs.¹⁹ Opiate use was considerable by post-1950s standards, yet carried out in culturally accepted, legal or semi-legal practices of self-medication and recreation.²⁰

18. Although Māori may speak with a single voice on current issues that affect all their peoples, their oral histories remain distinct and cannot be reduced to a single account.

19. Marijuana was introduced and used legally as a medicine, to a significant but unknown degree (Yska, 1990). Alcohol has been regulated, but never totally prohibited, despite the efforts of a energetic temperance movement from the late-19th century. The sale and public use of tobacco was normal and legal until prohibited in public places in the 2000s. Functional food and beverages with drug effects, such as sugar, tea, and coffee, have been central to New Zealander’s domestic and work life. See Smith & Tasnádi (2006), Avena, Carillo, Needham et al. (2004), Avena & Hoebal (2003), Colantuoni, Rada, McCarthy et al. (2002), O’Connell (2004), Drewnowski et al. (1995), Drewnowski et al. (1992).

20. See Eldred-Grigg (1984: 110-115, 234-240, 242). “... opium drinking was widespread. People in all walks of life, from ladies to prostitutes and shepherds to politicians, drank opium freely” (Eldred-Grigg, 1984: 112). Opiates feature in public advertisements for medication (Yska, 1990: 10). An *Opium Prohibition Act* was passed in 1901 to appease ethnic hostility against Chinese residents, and also associated with Christian influences and medical opposition to ‘quack nostrums’ and competition. However, this law only applied to solid opium suited for smoking, not the liquid preparations popular with non-Chinese. was not enforced with any rigour against non-Chinese (Eldred-Grigg, 1984: 236). No following legislation criminalising the possession of substances was enacted in New Zealand until the *Dangerous Drugs Act* of 1927. However, access to some drugs was formally regulated by the *Sale*

In the 1940s, large quantities of cocaine, heroin and other opiates were legally imported for prescriptions and OTC medicines, such as cough mixtures. Much was legally prescribed and dispensed, despite records showing that about half also vanished from the record keeping system (Lee, 1987), suggesting recreational, dependent, or otherwise deviant use. Intriguingly, few social or medical consequences have been recorded about a degree of drug supply that would later be treated as inherently harmful, dangerous, and a social evil. By the 1950s, international pressures led to increased surveillance of pharmacists²¹ and GPs (Lee, 1987). Recreational drug use then became an unrecorded, illicit underground activity, with very small numbers reported (Kemp, 2004). In 1965 there were only 113 arrests for illicit drug use in New Zealand out of a population of approximately 2.6 million (Statistics New Zealand, 2005). Nevertheless, the number of reports of drug use and enforcement efforts increased significantly during the 1960s (Newbold, 2004: 54-60), despite or because of an aura of cultural deviance and risk taking. There were at least 21,000 charges laid in 1995 from a population that had expanded to 3,706,700 (Kemp, 1996).

Modern western societies legitimise many pleasure-seeking and performance-enhancing technological practices, some involving substances that increase health risks, for example Viagra and alcohol. HIV/AIDS is transmitted by both unsafe sexual activity and the unsafe sharing of syringes, particularly in situations conducive to risk-taking, such as inebriation. The initial prevalence of HIV in New Zealand was very similar to that recorded in Australia and the United Kingdom (Skegg, 1987: 4). This is not surprising in a modern global culture where the practices of enhancing physiological pleasure and capabilities are often valued, for instance as a right to pursue happiness. The campaigns to resist legal prohibitions on homosexual and drug-using practices have drawn on such cultural values, as well as on pragmatic arguments that prohibition entails more costs than benefits. Such cultural values, along with financial and other pragmatic constraint, have provided influential frameworks for legislation and other codifications of permitted behaviour.

There is a clear ideological directive in some interpretations of Christianity to oppose any competing values and practices of happiness. For instance, in 2007 Cardinal Biffi reminded Catholics that: “[If] relative values such as solidarity, love for peace and respect for nature ... are given an absolute value or uprooted from or placed in opposition to the proclamation of the fact of salvation, then they become the basis for idolatry” (Wooden, 2007). Values such as enhanced performance and pleasure through gay sex, drugs, and music could be opposed on theological grounds of dogma (Rome, 2007: B4), even if not specifically forbidden in authorised versions of the Old or New Testaments. A significant proportion of Christian theological dogma carries a

of Poisons Act, 1871. This control was informally ignored, with newspaper editorials proclaiming that although opium smoking was pernicious and debased the individual, it was neither a scandal nor an affront to public decency (Eldred-Grigg, 1984: 110-111).

21. Pharmacists had formed a professional association during the 1870s. Early legislation regulating pharmacists or substances they traded in was passed in 1895, 1900, and 1902 (Eldred-Grigg, 1984: 113, 238).

prohibitionist history. This influence is illustrated in the more local and specific instances of Christian political goals expressed in the platforms²² of the United Future and Destiny New Zealand parties, which indicate a continuing interest in influencing policy on sex practices and substance use. These examples illustrate why religious interests and influences cannot be excluded from analyses of policies that regulate pleasures, health, and prohibitions.

Until alcohol-focused temperance movements later emerged, colonial attitudes in New Zealand were not founded on drugs or their use being an innate social problem (Eldred-Grigg, 1984: 110-111), but rather as a potential problem of overuse that might pose a risk to a specific individual's soul (Eldred-Grigg, 1984: 109, 234). During the initial decades of the twentieth century, such perspectives were replaced by those of professional medicalisation²³ that followed developments in the UK. 'Publics', or 'populations', of patients and potential patients altered in their delineation, as both social problems and social entities, during these developments. The UK influences on the criminalising of opiates added to a cultural movement promoting social health and moral hygiene (Eldred-Grigg, 1984: 234, 240, 243-244), and received greater impetus from a cultural distaste for Chinese residents (Newbold, 2000: 163-165, Kemp, 1996, Eldred-Grigg, 1984: 236). New Zealand developments were similar to those in the US as well as the UK (Kohn, 1992) during the same period. These New Zealand changes first accompanied, then have seemed subsumed within a global system of prohibiting particular substances.²⁴ Health and religious²⁵ 'best-practice' came to proscribe the private use of substances for recreational and performative goals, while approving of the use of mood and health-enhancing drugs²⁶ if under medical direction for health goals.

The scale of drug markets and arrests offers some initial parameters, yet also some reasons to be wary of quantitative analyses when the sources and measuring methods have been unknown, or unable to be verified. The NEP's initial official estimates of 2,500 IDU in 1986, based on the records of drug treatment centres and prisons, were later shown to have been derived from skewed

22. For example: "Destiny New Zealand opposes: Any move to legislate recognition and normalisation of same-sex relationships and the promotion of such relationships to be equal to the traditional form of marriage. ... Oppose any attempt to legalise cannabis and any other Class C Controlled Drug" (Destiny New Zealand, 2007). United Future "Oppose the decriminalisation of cannabis and any liberalisation of other drug laws. ... Regularly review the classification of drugs ... and only allow them to move upwards into more serious classes of drugs. ... make drug dealers an accomplice to any crime committed by their 'customers' ... Require education programmes dealing with risk-taking behaviour in adolescence, such as drug use, to present abstinence as a genuine option, rather than the current focus on 'harm minimisation'" (United Future, 2007).

23. See Davenport-Hines (2004: 365-375), Marez (2004), Courtwright (2001, 1997, 1982), MacCoun & Reuter (2001), Marks (1990a, 1990b), Eldred-Grigg, 1984: 199, 201, 234, 236, 240).

24. This occurred as New Zealand Governments after 1912 signed and adhered to a series of international treaties. These treaties initially combined elements which conflicted in being both medicalising and criminalising, but became increasingly North American influenced towards medical professional support for criminalisation. The 1948 *Paris Convention* seems especially significant in how it strengthened the International Narcotic Control Board (Kemp, 1996: 151-152). New Zealand and Australia were promptly accused by this Board of having the world's highest per capita consumption rates of heroin and cocaine, much being medically prescribed. The New Zealand Government complied and banned heroin importation in 1951 (Lee, 1987; Kemp, 1990, 1996: 154), making it impossible for previous practices to continue. These previous practices may have effectively constituted an informal 'professional best practice' of palliative care through drug maintenance prescribing. Patients and doctors presumably

data. IDU numbers 'in the wild' were not represented by those held captive or seeking support for problems of addiction. New Zealand research, based on World Health Organisation methodology, indicated that in 1997, an estimated 13,500 - 26,000 out of a total population of 3,802,600 New Zealanders had acquired an opiate dependency.²⁷ A later hepatitis C study accepted a known underestimate of approximately 20,000 to 25,000 people with injecting drug experience (Nesdale et al., 2000: 16).²⁸ Newbold argues for a figure of approximately 11,000 opiate users, both licit and illicit, of whom approximately 6,000 were addicted, at any time after 1990 (2004: 65-66). A comparison survey of drug use in New Zealand, carried out nationally in 1998 and 2001,²⁹ has indicated that the number of people with IDU experience remained stable at approximately five percent of the population.³⁰ However, the total population increased from a 'de facto' estimate at the end of 1989 of 3,410,400, to a 'Resident Population' estimate of 3,851,200 at the end of 1999 (Statistics New Zealand, 2005). If these estimates are equivalent, and if the approximation of five percent applied eight years earlier in 1989, then these statistics suggest an actual increase in recorded IDU numbers of 22,040 people over ten years, an average of 2,204 per year.³¹ The Nesdale et al. model (2000) estimates a regular increase of 14,000 IDU from 1990 to 2000, an average of 1,400 per year, the population having doubled within a ten year period. It is apparent that, given these trends, the public demand for syringes from the NEP is very likely to increase.

Health officials paid increasing attention to HIV/AIDS during the mid-1980s. Community programmes that focused on gay sex, commercial sex-work, and IDU were developed. The NEP was formally established in December 1987 by amendments to the *Health Act* that legalised the provision of syringes, but not their possession, while creating a legal defence against a charge of possession. Accompanying amendments to the *Misuse of Drugs Act* (New Zealand Government, 1975) partly decriminalised the possession of syringes. *The Health (Needles and Syringes) Regulations 1987* were gazetted before 1988. Between 1988 and 1998 the terms of these regulations were changed by decree several times. Except for one instance when syringes were

substituted other substances and forms of access. It is not clear whether temperance movements in New Zealand were an exception to the previous pattern, or to international temperance patterns. It seems possible that the New Zealand temperance developments provided a means of shifting from a moral mechanism/model to a medical mechanism/model of understanding and working in an infrastructure of engaging with substance use. See also United Nations conventions on 'narcotics' (UN, 1961) that covered many other types of drugs.

25. Religious prescriptions for social purity and abstinence were often fervent in the non-Episcopal churches (Eldred-Grigg, 1984: 185-186) yet did not proscribe ritual and spiritual methods of intensely altering consciousness. Unfortunately, religious influences, often treated as private rather than social, have seldom featured in New Zealand histories and social science analyses. See Stenhouse (2004), Davidson (2000), Lineham (1991), Breward (1979).
26. Such as selective serotonin reuptake inhibitors (SSRIs).
27. See Ministry of Health (1997); Sellman et al. (1996). The total resident population at the end of 1997 was estimated from census results to be 3,802,600 (Statistics New Zealand, 2005). The estimated 0.3% - 0.6% of those with opiate using experience is in the order of the figures used in the Nesdale model of 0.7% of the total population having acquired hepatitis C.
28. The number of occasional users was acknowledged to be most likely an underestimate. However, the uncertainty in earlier IDU population data was reduced by combining Australian models of distribution patterns with particularities of the history of New Zealand drug markets. Gaps in historical data before the 1960s remain, and the ratio of occasional to regular users had been unreported in earlier records. An Australian model of pyramid drug market distribution (Marks, 1990b) in Melbourne was used to estimate the ratio of occasional to regular users during the

required to be labelled, all the changes were to relax previous constraints. In 1998 an amendment to the *Misuse of Drugs Act* replaced the 1987 Regulations (New Zealand Government, 1987) with the *Health (Needles and Syringes) Regulations 1998*. A further amendment occurred in 2005, when the onus of proof in charges of possession of syringes shifted from the defendant to the prosecution. Nonetheless, possession of syringes remained illegal if intended for any illicit purpose, such as injecting illicit drugs.

Since 1988 the NEP has supplied syringes through two types of outlet. The initial type consisted of pharmacies. In September, 1988, seven months after the NEP began, there were 149 registered pharmacy outlets (Kemp, 2004). Between that time and 2004, registered pharmacy numbers varied sufficiently to cause alarm, halving at times over the first seven years (Nimmo, 2004. pers. com.). In 1994 there were 152 pharmacy outlets (Walker, Brady, & Baker, 1994:1). In late 2004 there were 170 pharmacies registered with the NEP out of 900 pharmacies in total throughout New Zealand (Sheridan, Henderson, Greenhill, & Smith (2005). The numbers of pharmacies supplying syringes through the NEP over the last decade generally varied between 100 and 200. This number and distribution was sufficient to guarantee a surface type of national coverage, except for remote rural areas, and excepting a small percentage of pharmacy outlets that IDU seemed reluctant to visit (Walker, Brady, & Baker, 1994).

Five months after the NEP pharmacies began operating in May 1988, an IDU peer group in Auckland was contracted by the Department of Health to provide NEP services. Four more groups formed by 1990. In late 1994, one peer group publicly³² collapsed, but was rapidly replaced. The five IDU peer groups formed a national federated body named Needle Exchange New Zealand (NENZ) in 1995. NENZ had been preceded by five successive co-ordinating agencies, all disestablished by government policy, the last succumbing by mid-1995. NENZ is a co-ordinating and service-provider body that meets twice yearly. NENZ services are of national scope, in contrast to the regional focus of its constituent member groups. NENZ elects representatives to the NEP Stakeholder Group, which meets twice yearly to monitor governance and policy issues. This Group includes representatives of the Ministry of Health, the Pharmaceutical Society of New Zealand

exceptional period of large-scale heroin importation in New Zealand from 1976 to 1982. The larger numbers in the Australian model and the detailed ethnographic information from New Zealand were combined to give greater confidence in this estimate, especially since it falls within the previous estimated range. However, the authors accept that future projections are problematic given the uncertainties of volatile drug markets and drug using practices.

29. See Wilkins, Casswell, Bhatta, & Pledger (2002: 45-46). This is the only national comparative study undertaken.

30. Those having ever tried heroin, homebake, morphine, poppies and other opiates were 3.7% of the total sample in 1998, and 4.3 % in 2001. I am assuming these drugs were injected. Those having ever tried other illegal drugs by injection were 1.2% in 1998 and 0.8% in 2001. Adding these I assume 4.9% in 1998 and 5.1% in 2001. Overlap between categories would reduce these figures, but I consider the measurements to be underestimates in any case. The point is that there was no great change.

31. 156 deaths associated with opiate use were recorded between 1990 and 1996 (New Zealand Health Information Services, 2005). However, only 93 people are recorded as dying from opiate related causes between 1995 and 1998, an average of 31 persons per annum.

32. Other groups effectively collapsed and reformed, but not publicly.

Inc., and the Pharmacy Guild of New Zealand Inc. (NENZ, 2005).

By 2004 there were twelve full-time peer outlets, two part-time outlets, and one de-centred service (Sheridan, Henderson, Greenhill, & Smith, 2005). The larger cities, such as Auckland and Christchurch, had begun to establish suburban satellite outlets. In addition, a new model of rural, non-outlet outreach and exchange was piloted on the West Coast. This 'bush-net' model involved flexible, ad-hoc arrangements where control was shared among local agents and a urban-centred support service. By 2004, NENZ was contributing to national quality control protocols in related fields and sharing leadership with public health professionals in combined research projects (Brunton, 2004. pers. com., Henderson, 2004. pers. com.).

In 1995, NEP outlets began being classified as either Level 1 or Level 2, depending on the commitment and comprehensiveness of service delivery. All the community-based IDU peer centres and several pharmacies were Level 2, 'dedicated' exchanges. The majority of pharmacies provided less comprehensive, more rapid Level 1 services, under the direction of protocols developed in the NEP by the pharmacies and community centres offering Level 2 services. In both Level 1 and 2 outlets, the supply side was fully commercial until 2004, with the syringes purchased by the IDU client at the time of the transaction providing a professional service fee and reimbursement for labour.³³ The number of syringes distributed by the NEP increased steadily to over one million per annum by 2000, with 64% supplied by community-based IDU peer group centres (NENZ, 2007). Surveys of NEP clients indicated that needle sharing incidents reduced from 50% of injecting occasions in 1994 to 6% in 2002 (Aitken, 2002: 5). Yet during this period, and increasingly after 2000, drug prohibition enforcement became more stringent³⁴ while the potential distrust felt by IDU for state-funded programmes correspondingly increased.

According to every account the NEP has been a remarkable success. It was effective and efficient (Aitken, 2002: 7) in achieving its key outputs and outcomes, since between 1985 and 2003, those diagnosed with HIV numbered less than ten per annum, including infections acquired overseas (Saxton & Hughes, 2004: 8). The NEP is estimated as having saved \$35 million in treatment costs (Aitken, 2002: 6). Yet given the ambiguities and on-going difficulties, how can such success be understood? It was not due to a rapid start that seized the key founding moments and people's

33. After this change, additional accounting systems have been required for calculating labour and managerial reimbursements (Henderson, 2004. pers. com.).

34. The New Zealand 'drug wars' intensified after 2000, partly due to one particular Minister holding a fervent anti-drug agenda. "The first action of the Ministerial committee overseeing the National Drug Policy after Mr Anderton became chairperson, following the 2002 Election, was to put in place an Action Plan for alcohol and illicit drugs. The first such action was reclassification of methamphetamine to a Class A harm drug. In May 2003 the Ministerial committee incorporated under that Action Plan a 19-point methamphetamine action plan due to the seriousness of that drug's effects. In December 2003 Cabinet agreed to amend the Misuse of Drugs Act to give Police and Customs greater powers, including search and seizure powers without warrants. The amount of drug material required to constitute presumption for supply has been reduced in relation to methamphetamine and methcathinone. There has been a reclassification of pseudoephedrine and ephedrine by way of Order in Council, with a view to penalising the unlicensed importation of such drugs" (Coroners Court, 2005: 65).

imaginings, thereby blocking other possibilities (Laugeson, 2001: 131-132), since the NEP was even more notably delayed and hesitant than other HIV/AIDS responses in New Zealand. It was not due to the initial numbers of HIV-positive IDU being low, since the initial prevalence was equivalent, proportionate to population, to Australia. There are better explanations. I point out that despite the tardy official start, IDU themselves took precautions even earlier and were assisted by pharmacists who were also prepared to act illicitly. This initial advantage was then built on by the NEP being as flexible as needed, not only by design but also due to a combination of institutional interests and prejudice, as officials and professionals preferred 'not to know'. Not to know what? Chapters 4 to 9 will describe what happened in terms of patterns of events and patterns of effects, together explaining a degree of social action in terms of a mechanism. But only a degree of social action, and a mechanism characterised by flexible ambiguity.

3 How has the NEP worked? Following logics, hybrid mechanisms, actor-networks

When I asked two key NEP managers³⁵ for their explanations of the way the NEP developed, they emphasised, among other factors including sheer good luck, that financial constraints and competition explained much about several important conflicts which had shaped developments. Yet such quantitative data, even about crucial social resources such as finance, can only explain so much. Such data do not explain how state-supported organisations run by active criminal associates could form, nor how the consequences and conditions of such formations might interact in later developments. Numerical amounts of money, time and people refer to stories³⁶ of extent and continuance, but not of what happened and how it continues to make a difference. The syringes did not 'count', in terms of quantity, as equivalent in number or type, since they were differently understood and of different legality in different environments. Such differences and consequences cannot be validly averaged or otherwise statistically merged into a smooth numerical index, though Latour points out how such shifts and translations of information between messy reality and numerical registers can be efficiently achieved in practice.³⁷ As I will show, a range of connective

35. These were Catherine Healey, co-ordinator of WIDE and NZPC from 1988, and Simon Nimmo, NEP National Manager/co-ordinator from 1996 to 2002.

36. Numbers are important, as is measuring in general, since numerical system-building activity takes place in a local context where the process always includes the measure and the measurer in relation to that being subjected to measurement. The significance of numbers can be analysed using qualitative methods, such as the relational network required for any measurement to become active, to change things.

37. See Latour (1999c: 47-64). Pickering (1991) has much of related interest to say about joining divergent and distributed entities into actual cases in ways that are contextually contingent. 'Translations' are involved in the development of durable innovations as described by Latour, and techno-economic networks, as described by Callon, Larédo, & Mustar (1997), Callon (1991). Callon's 'translation' focused on changes in the positioning, timing, and understandings of circulating intermediaries which maintain system boundaries as significant social features. Latour has drawn attention to the forms and forces involved in the sometimes cyclic activity of 'immutable mobiles'. Translation involves the movement of meaningful objects across system boundaries, in ways that mean different things to different actors, depending on their positioning. My analysis has paid attention to how both innovation and sustainability have been facilitated by circulations of syringes, funding, and information. These circulations contributed to the stability of the NEP, and at least partially explain both the exceptional and sustainable aspects.

effects emerging from the articulation of different motivations and meanings.

My account of the NEP was informed by a general concept of ‘hybrid vigor’, where an unfixed, provisionally stable and productive arrangement of a small number³⁸ of differences can be held together in some way.³⁹ The concept of hybridity is conventionally associated with breeding, where the crossing of normally distinct genetic sets produces an unusual organism. However, actor-network approaches encourage a sceptical querying of explanations that rely upon the prior ‘fixing’ of an entity as either natural or social in any sort of essential identity and qualities. Rather than a biological metaphor, where organisms tend to be associated with a given nature as integrated and harmonious, my use of hybridity is better illustrated by a metaphor of artifice. For instance, when constructing classical Japanese swords, different alloys of steel and iron are folded tighter and tighter together in the forge until the respective grains and lamellae form an intimate alliance (Untracht, 1982: 364-365). The opposed characteristics of durability and edge hardness, which are so desirable in a blade, depend upon the connecting of dissimilar surfaces. This is why the joining process stops before the differences in metallurgical constituents ‘assimilate’ into a less effectual homogeneity. Such a mechanism is both quantitative and qualitative, since the types of different articulated surfaces, their size and overall configuration, are just as important as the chemically alloyed characteristics of each element, and on the overall shaping of the outside ‘sword-user’ boundary. Blade and environment engage at such boundaries as distinctive systems of social action where motivations mix with conditions of possibility.

This metaphor informs an understanding of the NEP⁴⁰ and peer-professionalism, in terms of human and non-human living systems engaging with technologies and tools. For instance, the social activity of an illegal ‘syringe/user’ hybrid in 1986 was significantly different from that of a ‘legal syringe/illegal user’ hybrid after the NEP began operations in 1988. In 1988, to dispense a syringe for illicit purposes was considered illegal and immoral. After 1988 such dispensing constituted the respectable work of a licit public health organisation. In the case of the NEP, the hybrid mechanisms I will describe worked by connecting viral ecologies, legislative systems, cultural

38. Hybridity frequently refers to mixtures of only two different things. This duality seems to derive from its original use in heterosexual breeding of plants and animals. My concept of hybridity shifts from dual to multiple.

39. This usage drew from a Buddhist analytical tactic of four-fold negation, which matched a pattern I observed in the NEP of ‘not this, not that, not both, not neither’. Yet my hybridity is not ‘transcendent’ in any sense of its meaning and activity being reliant on its ‘standing outside’ experienced reality in some domain of metaphysical ideals. My hybridity also does not refer to joining in the sense of merging, or of producing a well-defined, internally stable product’ exhibiting a boundary only with externalities from some accumulation or re-arrangement of differences. If such a hybridity coalesces into a single thing, or stops activity, or separates into unattached entities, it is no longer hybridly productive. This is not an organising logic of aggregation, where basically similar elements become more active through greater impact of higher numbers. Nor is it a logic of partnership, where differences complement each other.

40. As a basically qualified welder (stick and oxy-acetylene) I have experience of controlling the heat input and speed of cooling of molten metal puddles, where the eventual grain characteristics and homogeneity of the weldment is as crucial as when forging a sword. In fact, swords of exceptional quality in the Middle East were frequently cast in a process whereby the cooling of the metal alloy led to differentials in grain structure emerging as a heterogeneous outcome from a more homogenous molten state. Various aspects of the NEP can be usefully modelled as ‘forged’, ‘cast’, and ‘welded’.

expectations, human individuals, and syringes. Some of the network elements were human, some non-human but alive, some non-human and not alive, yet none can be ignored, despite some seeming more influential than others at least in the short term. The NEP's antagonisms were forged into close proximity and articulated⁴¹ through key jointings, acting partly as a mechanism and partly as a work environment.

The term 'mechanism' might imply predictability to some, but I disagree, since mechanisms can be random or otherwise indeterminate. I do not suggest that the NEP's mechanisms lead to predictable outcomes. Actor-network descriptions are a type of positivism that require well-evidenced information and meanings, but are not determinist in the sense of all outcomes being inevitable and caused only by a single, or a few prior events. Instead, the networked environment is 'conditioning'. Suddenly emergent things are acceptable if they can be demonstrated, and constant difficulties produce sites of conflict where chance and complexity contribute to outcomes that are unpredictable. The NEP was certainly positively determined and planned, at least initially, but I do not refer to this planning as the criterion for the 'mechanism' I draw attention to. Instead, I emphasise two other aspects. First, I point out that a provisional sustainability emerged in the NEP alongside an on-going selection process based on pragmatic workability. For instance, key IDU peer managers considered the NEP's legislative framework to be irrational (NEXUS, 1992: 2; 1990c, e, f), and did not follow directives blindly when obstruction, disobedience, and work-arounds seemed preferable. The workability emerged from understanding the everyday institutional actualities and IDU expectations that in becoming mutually involved were thereby able to work pragmatically.

The second aspect of mechanisms relates to my method of following network linkages through the movements of objects such as syringes, viruses, and documents. I emphasise how significance emerged from the NEP's linkages of such objects with information. I found many connections in some places, and few in others. I considered both the presences and absences to be significant. However, the quantity of reported connections only told so much. Some links seemed more contextually significant than others within the local system of the NEP and NEP research because they outlined a local system, a mechanism of effects, in a history of events (Latour, 1999c: 305-306), which made some possibilities more or less difficult than others.

41. To avoid confusion I should probably specify my usage of the term 'articulate'. In particular, I do not take up the somewhat structural determinist contexts of the analysis of class-cultural struggle that derives from Gramsci (1971), and has been developed in an even more nomadic direction by Stuart Hall (1996). I do, however, borrow from that stream the concept of articulation as a closeness and a conflict between being and becoming, and involving both linking and speaking. I also invite attention to the use of Hall's 'articulations' in studies of ethnic group meanings and cultural aspects, since IDU may well be treated as an ethnic group with a characteristic ethos. However, I do not find Latour's definition of articulation (1999c: 303) very useful. Latour emphasises how the term does not only refer to language, but has universal application. Although useful to a point, this also evades the point, or more importantly, the joint. The clarity referred to by 'articulation' derives from segmentation and jointedness (Latin *articulare* - to divide into joints), both of which tend towards a local and linear perspective, or following, of a wider configuration, or network, constituted from segments and joints as well as other entities.

The actor-network approaches I utilise offer ways of directly linking objects, meanings, and motives. Actor-network approaches involve a set of principles and sensitivities rather than a pre-ordered schema for research to be plugged into.⁴² The close physical detail of objects, the wider infrastructural patterns of pseudo-objects, and the personal motivations of actors, share a stage as interactants that ‘perform the actual’, and enact their performances in stages of timing and tactics. My actor-network approach involved engaging with both the contentious and regular activity of the NEP by following its connections, while noting the rationales and patterns of ‘clumping’ and ‘labelling’ into named, consolidated entities. My input into the substantive social history in chapters 4 to 9 was as a partial participant, not as a fully detached observer, since my research has been ‘entthreaded’ within the same multi-dimensioned, clumpy reality as that studied.⁴³

It made an actor-network type of difference whether an argument for funding was found in an archived document with a private sending address and bent spoons⁴⁴ in the kitchen, or an NEP office address visited by commercial carriers, where financial records were filed, and competencies displayed to a public gaze. In both places new and used syringes were likely to be found, so I could not merely note the presence of syringes. I also had to follow their movements and stories as these were modified by other objects and understandings in network practices. The meaning of an address on a letter could not be touched, unlike the physical object of the letter, yet its actuality at times connected to my memory of actual places, still present in a story that also involved bent spoons and filing cabinets in a range of potential articulations. These materialities and meanings made a difference, but within particular frameworks of understanding, which might, or might not, be specified at the time or in research.

The research is informed by a specifically ‘symmetrical’ actor-network stance that has involved ‘neither condemning nor condoning’ the logics of illicit drug use and IDU perspectives. I adopted this stance to approach all aspects of the NEP case with the same methods and to deal even-handedly with the whole case. This stance seems even more appropriate in being the formal

42. This is why my approach will not necessarily be followed by other actor-network researchers.

43. Actor-network approaches are a theory-averse, innovative form of interactional positivism. However, they are highly theoretical in an immanent sense where theory is done by circulating close, but not too close, among cases (Latour, 1999c: 69-79) rather than made into a distinctive entity. In this respect the methods are located within the lineage of sociological studies of economies, technologies, and sciences. This field has pragmatist, historical, and interactionist footprints leading back to the ‘positive social science’ of Comte’s sociology and the establishing of history as a University discipline in 19th century Europe. Actor-network approaches overlap with anthropological and geographical interests in the locales of material culture. Actor-network following methods are similar to ethnographic tactics of using a researcher’s embodied interactions and situated vulnerabilities as a qualitative instrument.

44. IDU often bend down the shank of a spoon so the spoon bowl sits flat when put down to cool in the process of cooking a taste. The spoon contains a mix of crushed pills or poppy latex that is heated with liquid reagents, then cooled and drawn up through a filter into a syringe. This home preparation, requiring a heat source and flat surface areas, partly explains the lack of a street injecting scene in New Zealand. Between the ‘Mr Asia’ period and 1994 (Walker, Brady, & Baker, 1994: 32), heroin was scarce in New Zealand and most of the affordable injectable opioid drugs have not been readily dissolvable in cold water. The spoon also provides a type of record. The most useful angle of the spoon is different from that required for conveying food into a mouth. Such spoons become recognisable and need to be controlled along with the nearby surfaces, raw drugs, reagents, filters, sterile water, and syringes that contribute to the safety of injecting.

operating principle of the NEP peer groups. This symmetrical stance encouraged me to explore and identify the basis for the trust expressed by IDU in the peers and pharmacists who run these outlets. Yet the trust by government agencies in an organisation that was itself trusted by illicit IDU, and could be confused with a criminal gang, also required study.

My approach involved attention to the way material environments, collective motivations, and social institutions intersected by means of physical objects including syringes, drugs, and quasi-objects⁴⁵ such as the NEP itself. Quasi-objects are like ‘black-boxes’ (Latour, 1999c: 304; 1987: 2-5, 130-132) in being larger and more complex inside than seeming on the outside. However, the key criterion of quasi-objects as I employ the concept lies not in the packaging of complexity alone, though that frequently emerges from studies. Also crucial are the packaging of contests and trials over definitions, the enrolment of different interests, and control over practices and behaviour as regards specific physical objects.⁴⁶ For instance, why have IDU been seemingly unafraid to return used syringes containing potentially identifiable traces of illegal drugs and their DNA, in a context where no transparent public protocols protect the ‘donor’ from the use of this information without their consent? IDU would never voluntarily donate such samples to law enforcement agencies, yet do to health services such as the NEP, despite health authorities frequently co-operating with police and despite health authorities permitting Corrections Department staff to place security and administration concerns above the health of inmates.⁴⁷

An unexpected experiment in surveillance, carried out by testing the syringes returned for exchange at NEP outlets, provoked my interest by not leading to any consequent expression of guarantees, nor any statement of ethical or ‘best practice’ protocols. The absence of this information, given the increasingly public concern with the ownership of personal, collective, and commercial information, such as DNA data, is explored in chapter 8. Exploring such a trial of collective interests requires first tracing the way in which IDU came to trust the same government system that proudly proclaimed its resolve to punish IDU or to stigmatise them as non-compliant ‘potential’ patients.

45. I use the term quasi-object to refer to an entity that is uncertainly and unpredictably physical-natural, informational, and cultural-communicative, without being purely any single one of these constituent attributions. This usage follows actor-network understandings. Latour emphasises that such attributions are categorisations from after the crucial activity of making a quasi-object work in practice, whereupon it can also be made ‘true’ as a natural or social ‘fact’. See Serres & Latour (1995), Latour (1993: 90; 1996: 213). Quasi-objects constitute areas and participant understandings of networks by circulating, and transforming meanings in shifts and translations as an inherent aspect of circulating, yet in ways that are always potentially contestable, and therefore of both ethical and political significance. Latour considers that quasi-objects are: “[r]eal as Nature, narrated as Discourse, collective as Society, existential as Being” (1993: 90). Elsewhere Latour specifies that quasi-objects are: “a continuous passage, a commerce, an interchange, between what humans inscribe in it and what it prescribes in humans. It transplants the one into the other. This thing is the non-human version of people, it is the human version of things” (1996: 213).

46. This is one reason why I do not follow a ‘complex systems’ approach. Complexity by itself explains little to nothing, if all situations are irreducibly complex. What then matters is how strategies of avoiding or making use of complex systems are organised.

47. As evidenced by the number of preventable deaths and injuries in prison, and by the Memorandum of Understanding that prevents Health Ministry personnel from publicly commenting on health issues in prisons unless first negotiating permission from Corrections Department personnel.

As I explored the journey of the NEP syringes and outlets from illicit beginnings to being normal and authorised, the amount and complexity of emerging information was drawn into increasing coherence by asking how the record of problems informed the stories of success. I noted that I was following syringes, along with IDU peers and peer organisations, down two somewhat parallel corridors of inquiry, one focused on the actual sequence of infrastructural developments, the other on the motivations and relationships between those participating in designing, using, and running the NEP. One process that has linked the two is path-determinacy. By this I mean that the constraints laid down in the form of durable structures provides the conditions that do not determine historical outcomes, but do provide unequal difficulties that make certain outcomes far less likely than others. Both types of explanatory frameworks are needed to understand the sorts of professional careers and jurisdiction that developed. Both types of question and sensitivity are needed to trace and identify the way institutions and organisations came to be assembled into a durable system. Where, and in what mix of structure and period, do the circulations of syringes interact with movements of money, documents, careers, trust/distrust, and surveillance that contribute to systems of governance? In pursuing these questions and instances I constructed an account that depicts the character of a unique case involving a specific, historical, local mechanism of hybrid interactivity.

4 Structure of the thesis

This thesis presents an argument that develops in steps from the NEP's founding moments and conditions, through a detailed, analytical, and conceptually-informed social history. The argument progresses towards an account of the NEP as a specific case, linked to a description of peer-professionalism as a principle that characterises the specific case, yet could be cautiously extended to similar cases. I have divided the stages of my argument into twelve chapters, grouped into four sections. In the first section, three chapters introduce the overall thesis contexts and arguments, then the methods of selecting information and the types of information analysed.⁴⁸ The second section groups four chapters that describe the development of the NEP by exploring incidents, structural effects, and events in a chronological sequence. In the third section, two social history chapters offer a thematic analysis of NEP developments, describing wider connectivities and consequences. Here I focus on those synchronic meanings, motivations, and goals which do not neatly fit a linear, historical approach. The fourth section integrates my sequential and structural approaches. Here I present my 'case for a case'⁴⁹ in three chapters, by focusing first on the

48. My research methodology does not depend upon a rigid ontological or epistemological framework. For this reason there is no theoretical framing chapter, although an informative, contextual discussion of methodology is presented in Appendix 9.

49. This legal metaphor of 'making a case' links to my scientific 'grounded case study' and my historical 'meta-case account'. See Yin (2003: 39-45)

grounded NEP case, then fully addressing my research question of capabilities by shifting to the meta-case of peer-professionalism that has permeated and informed the grounded case of the NEP. The thesis concludes with a final chapter that revisits my initial concerns and my questioning of ‘capabilities’ in terms of the overall pattern of thesis material, my argument, and several on-going NEP issues.

My chapters effectively address the key questions, foreshadowed in my Preamble where I presented the biographical context through which this research developed. The first chapter poses three questions. The first asks why one might bother to research needle exchanges. The second asks what general sort of work needle exchanges do. The third asks where this research is positioned in relation to the preceding questions. In this introductory chapter I present a resource kit-index of sociological contexts, illustrations, methods, and reasons for my calculated stroll along a needle-strewn path. I foreshadow my argument that the capabilities of the NEP result from its hybridising of antagonisms between IDU, officials, and health professionals. I introduce two previous explanatory stories (Yin, 2003: 29), indicating where my account diverges. I outline key contexts, such as harm reduction, mechanisms, and networks that initially informed my research and continue to offer useful ways of thinking about NEP issues. I present case contexts in the form of a succinct overview of NEP dates and parameters. Finally, I specify how my thesis argument develops in steps through chapters and sections.

As my research developed I confronted a series of cascading questions. For instance, how can a researcher trust what drug users, officials, and professionals have said when their motives and loyalties seem so self-centred? How can one make sense of diverging, often antagonistic stories? Can one rely on expert authority and clarity of memory? Do stories contain their own validating signatures? In my research I gathered many received truths, none of which are completely trustworthy, except as its actuality of being its own story. I also took into account my memories and current experiences of syringes and documents as physical objects that expressed their own ‘facticity’ through their being related to other stories.⁵⁰ To outline my approach to such methodological questions I describe in chapters 2 and 3 how this research enrolled material objects (imbued with everyday meanings), as well as movements (of focused information packages), together with previous accounts (by professional and academic authorities). The combination of these elements support my argument in three crucial ways. First, the specific indexing of these seemingly incompatible elements will provide reviewers with an adequate number of demonstrable instances from close to the core of the NEP case. Second, my accounting of how the direction of analysis and selection of source material combined to mutually influence my argument will provide reviewers with an adequate description of my matching of goals to methods. Third, the relationship of a knot of relationships to a wider environment over a long duration will provide reviewers with

50. See Latour (1999c: 116-117, 120-122, 131-133).

an adequate description of the boundaries in both time and interactional space of the NEP case.

Chapter 2 lays out how I accessed and selected my archival and interview sources and their particular features. In this chapter I explain how the methods, and particularly the logics of the thesis, were source-attracted or emergent, not hypothesis-driven. My analytical understandings and directions were informed primarily by engaging with a range of embedded information sources, although my analytic sensitivities have been informed by wider academic contexts. My actor-network approach is described here because it is a following rather than a conjecturing method, and it follows sources, like any good detective.

In chapter 3, I detail the key approaches, stories, and literature that informed my analysis and shaped my ongoing selection of sources. Here I specify my assumptions and analytical methods, in consideration of the great number of different qualitative research methods that might have been used (Plumridge, 2000: 454). I explain how these elements appeared to me, and how they connected to each other, as well as how significance emerged from such inter-linkings. I outline the way I use key terms, such as mechanism and hybridity, to refer to processes and conditions of network selectivity. I explain how I embed historical and actor-network methods⁵¹ within a narrative, linear approach, similar to building up a portrait that expresses character.

Where do the NEP stories begin? Is there only one starting point for a definitive history? Or are there a number of versions of the NEP developments, all of which might become authorised? If these are not linearly sequenced, one after the other, how can such stories be told together? Did the NEP's hybrid, organising networks smoothly co-evolve or adapt in steps to its messy environment? Could the continuing alignment of work, actors, and environment be guaranteed? In the chapters of the following section I address these queries by describing key details and temporal linkages.

Chapter 4 presents the responses to HIV/AIDS by fractious alliances of gay community organisers, Department of Health officials, and medical professionals. Driven by community organisers, this alliance established a principle of policy participation and service delivery by affected communities. By operating close to the highest levels of ministerial advice, the representatives of these affected communities bypassed the dominance of clinicians and their established expertise within the health sector.

In chapter 5 I describe how the fractious alliances of the previous cycle of development outlined in chapter 4 then consolidated. This consolidation provided a partial model for assembling and reconfiguring a regulated pharmacy-based NEP out of the illicit activities of a handful of exceptional pharmacists. I follow how the crucial legislation enabling the development of the NEP

51. The seeming simplicity of actor-network accounts can be deceptive. Yet deception can be necessary when social research involves a process of cheating the social rules that keep crucial information secret. The methods of critical research evade, dissolve, undermine, or otherwise deviate in ways which are framed as licit and worthy of funding.

was driven into and through parliament while in linked developments, pharmacists were enrolled as a professional body into a prospective management plan, and a contractual relationship was negotiated for commercial syringe supply.

I describe in chapter 6 how the entry of IDU peer groups into the delivery of NEP services, in terms of two health groupings and two goals, where concepts of peer counselling were 'negotiated' between several proposed models. The negotiations led to the contracting of the initial peer outreach group as an ad-hoc measure that proliferated.

Chapter 7 presents a case study of the failure of peer-professional hybridity in a peer group which collapsed and was replaced by a more professionalised peer organisation. Close examination of this case shows how a peer-professional environmental niche, which provided opportunities for careers, occupations, and forming organisations, has in practice been constrained in scope and scale, while requiring continual maintenance of its network positioning.

How was information about the NEP's outcomes linked to the founding concerns over IDU motivation and safer injecting practices? How were the syringe movements organised in terms of economies and management of outputs? In chapter 8, the connections between syringes, biomedical testing, representation, and trust are laid out. I show how IDU and officials placed peer-professionals in a stressful, yet strategic, intermediary position of trust, producing differentials in stability.

I describe in chapter 9 how long-standing tensions shaped the development of regional and national infrastructures, while simultaneously, commercial and corporate expertise offered different forms of professionalism from that based on health education and outreach. I describe how these two sets of differences stabilised the peer component of the NEP while facilitating industrial conflicts with the Ministry of Health over policy relating to NEP cost increases.

An inter-chapter then presents interview excerpts, in the form of a short dialogue between two Christchurch peer-professionals. These illustrate and contextualise the scope of their perspectives on professionalisation and IDU community needs.

What can this NEP case 'do', and how is it uniquely intriguing? What can be learnt, and how could one identify where such lessons might be applied elsewhere? In the chapters of the following section I pull back from the detail and chronological focus of the previous section. My argument in Chapter 10 refocuses on the NEP case as a whole, by integrating the preceding themes and highlighting patterns. My argument is widened and solidified by directly cross-linking a range of issues and stories. I show how some past events, but not others, continued to directly influence later events by remaining present as path-dependencies or active factors in the NEP's on-going capabilities.

Chapter 11 focuses on peer-professionalism and other selected themes identified in the NEP case across different times and locations. These themes are grounded in, but not necessarily limited to the NEP case. Here my thesis of peer-professionalism is developed and delineated through a discussion of the positive evidence, significant absences in NEP coverage, problematic gaps in source material, and my critique of some alternative explanations. Peer-professionalism is presented as a response from, but also perhaps ‘by means of’ the NEP. Peer-professionalising is related to the NEP’s environment of antagonisms, as well as an extension to previous explanations based on a concept of partnership that too easily slides over rather than digging into the NEP case. In this chapter I argue for a ‘strong emergence’, where ‘peer-professional’ directions and tendencies observably altered the environment they emerged from, despite not being specifically referred to in such terms by those involved. I point out that the social history I provide in this thesis shows that actors understood peer-professional logics and necessities. I propose that this evidence constitutes support for the abductive and inductive logics I employ for selecting and analysing information. This chapter reinforces my claim to have used a rigorous process of analysing demonstrable evidence according to well-founded sociological principles of practice.

Chapter 12 is a type of coda that returns to methodological accounts, not from where the thesis began, nor as suited for an introduction, but from the narrative analysis used during the exploratory process. In this Coda I indicate where useful cross connections and extensions have led from the initial concepts that informed the context of my understanding, to more specified forms that have appeared in my better understood account of the NEP. The purpose of this final chapter is to invite reflection on the relationships between the grounded methods of this case study and its consequent account (Yin, 2003: 22-24), by distinguishing where the conceptual boundaries of the research, as a case, have been positioned and where they might lead.

Configuring sources

I learn through my own inhabiting of the figure of the cyborg about the non-anthropomorphic agency and the liveliness of artifacts. The kind of sociality that joins humans and machines is a sociality that constitutes both, so if there is some kind of liveliness going on here it is both human and non-human. Who humans are ontologically is constituted out of that relationality.
(*Birth of the Kennel: Cyborgs, dogs and companion species*. Donna Haraway, 2000c:np, with shifts in emphases)

How is it possible to study needle exchanges, and what sort of criteria require attention? Does my method of analysis locate the sort of information it needs, and are my sources of information credible? Could the method be duplicated, or is it a unique approach made incommensurable by my sources or analysis? Might the bits be put together differently, or is the information sufficiently complex in its shape that only one combination satisfies all the criteria, despite the expected gaps of an empirical world account? These questions are addressed in this chapter as I relate the NEP's sequence of development to the records it generated. These records referred to other documents, objects, and people. They travelled, first circulating, then selected according to their seeming significance or insignificance for discarding or deposition in archives. My approach entailed following these documents and thereby following the practices of people and the movements of things. I also followed changes in legislation, organisational boundaries, professional jurisdictions, and in logical rationales. My goal was to better understand a particular nodal cluster, or case, within this environment by overcoming or working around the difficulties of too much, too complex, and too little information. In this chapter I lay out the strategies I used, explain the criteria applied in selecting material, and invite positive critique.

I 'followed' the movements and linkages where different 'informational objects' intermeshed with logics, goals, legitimations, and other stories⁵² as I developed a portrait⁵³ of the configurations of the NEP case. My method discriminated between the arguments, analysis, accounts, approaches, and the stories that I used. Since the stories about the NEP and its contexts were fewer than I desired, yet ramified into wider policy contexts and embodied environments, I wanted as much information as possible, but could only deal with the most relevant and directly involved meanings. Accordingly, I applied a general criterion of tracing the stories that were indicated as relevant by their connections, for instance in the same documents, or archival filing category, or by the naming of actors and key objects. These story networks identified intensities and gaps in meaning that addressed my logical and tactical difficulties in configuring and signifying information.

52. I link theories about the social stories of governance structures and institutional logics (Campbell, 2004: 57-61), Bütte (2002), and Scott et al. (2000) with written sources, interview statements, and participant observation.

53. Portraiture blends aesthetics and empiricism to reveal the activity, complexity, and details that shape processes of organising. The methods articulate literary logics with cultural sensibilities, and scientific rigor to produce 'an intrinsic work' (Lawrence-Lightfoot & Hoffmann Davis, 1997).

In my first section I describe my actual methods and sources. The research was source-led, in that the degree of relevance was indicated by the network linkage among objects and stories. In the following section I describe actor-network approaches used to address the research problem of selecting sources for information. The ‘causal’ events and effects I will describe were pervasive and distributed, in fact better described as conditional. As such, their analysis did not rely on sources being specifically categorised within a prior theoretical framework that determined their selection. In the third section I describe how my actor-network approach involved following what the case situation offered, while assuming a stance of general, even-handed symmetry regarding my reasons for selecting and methods of evaluating the stories of actors.

1 Documents, conversations, and sense-making

Three significant factors influenced my criteria for source material. The first was the significance⁵⁴ and coherence of published material as available to people when making decisions at the time.⁵⁵ Another factor was the re-conceptualisation of the case questions and the significance of details in response to emerging patterns of meaning and explanation from a researcher’s later perspective. A third factor involved my evaluation of the degree of selection bias caused by difficulties of access and the preservation of source materials. Since this was exploratory research I did not attempt to preselect or randomly sample documents and interview participants. Instead I used a process of following the articulations and mechanisms⁵⁶ of the case, working practically with what materials could be made accessible, sensitised by the logics of systems of knowledge production.

I prioritised documents over interview sources for reasons that emerged during the research process. I had initially considered that interview-based analysis could be useful. Accordingly, I prepared an unstructured interview information sheet, formulated an interview protocol considered suitable⁵⁷ for working with illicit members of marginalised groups, and applied successfully for Human Ethics Committee approval. As it eventuated, I did not rely heavily on interview methods and did not use questionnaires at all. The different types of participants, the very low number of key decision-makers, the unfamiliarity of most IDU clients with NEP history, and the then unknown areas of particular significance, all argued strongly against questionnaire methods. My few key interviews fleshed out and otherwise supported a reliance on documented accounts. This

54. I searched the records for mentions of where chance events, such as personal biography and historical ‘accidents’ affected the ‘good fit’ between options and goals.

55. Every source has been considered to contain systemic evaluation frameworks, and implicit or explicit theorising, which have informed the research.

56. Such concepts of articulation and mechanism are described by Deleuze & Guattari (2004), and appear in some actor-network ways of looking, as if from inside, along the components of a mechanism being studied. I was not focused on this stream of writing when I began the research, but upon conceiving of a hybrid mechanism I looked for previous theorisations of mechanisms. However, I do not go so deeply into articulation and ‘folding’ as Deleuze & Guattari, since I reduce my theory to the minimum needed for the case of the NEP within my available resources.

57. By people not participating in illicit drug markets and not publicly supportive of the illicit aims of IDU.

choice emphasised the logics and potential shifts in significance involved in analysing the writing and preservation of documents, as compared with engaging with ‘subjects’ and their remembrances in face-to-face interviews. I recorded and personally transcribed the interviews. Most of those selected for interviewing spoke in their capacities as representatives of organisations. However, I also heard disclosures that could not be used in this thesis.⁵⁸

I found myself unwilling to try to overcome the distrust of surveillance by IDU. I myself strongly empathised with this distrust as being necessary for survival as an IDU. Nonetheless, since the period when I lived and socialised with IDU was a decade past, I would have needed to take an overly intrusive approach to access and motivate enough participants for a primarily interview-based research method. This difficulty helped me identify the importance to the NEP of the physical presence of practicing IDU peers who could engage with IDU clients within the parameters and understood codes of mutual respect, yet in a neutral, mutually beneficial encounter.

Asking illicit people to acknowledge an official research questionnaire and ethics document falls outside the parameters of everyday normality, and risks chilling relationships. It can increase the risk of introducing extra biases to a research situation. If using an ethnographic approach of maximising immersion and minimising experimental interventions, I consider that such research would need to be based at an operating needle exchange in order to compensate for any reinforcement of outsider labels and distrust. Yet interviews based at exchange outlets would, unless spread over the country for a short time at each exchange, unduly prioritise the perspectives of that peer outlet over others in different regions. I acknowledge such a bias in my personal background and wished to reduce rather than increase this potential distortion.

I did not wish to organise a national interview programme, irksome to all the administrators involved, without having first explored the archival records and found key themes so that the time investment of all those contributing would be most readily justified. Furthermore, I doubted that the clients attending and the peers working in exchanges would be, for the most part, any more informed about the founding of the NEP and developments in the policy frameworks than I had been when living and working in that world.

I wanted to know how IDU perceived the NEP, whether any concept of changing motivations was involved, and how the possibility of changing motivations was framed, if at all. These perceptions related to some of the founding goals of the medical professionals who, rather reluctantly, agreed to support the initial NEP concept. However, such questions and evaluation raised the problems of comparison and meanings, extremely difficult to engage with in a short time frame with no autobiographical texts by IDU to effectively extend the time and depth of reflexivity. Instead I

58. Except for indicating areas to look into, and in reminding me of my personal experiences which have not required ethics committee approval.

relied in part on my memory of discussing such issues when working at CIVDURG, and in part on reports, notes, and draft policy documents from the peer exchange archives. This range of material was sufficient to show how IDU generally perceived the NEP, and how peers viewed IDU and the NEP, but was not sufficient for a detailed, localised analysis of how such perceptions had changed and what the various actors felt about such changes. This range of material was only adequate in the single case of CIVDURG, which I present in chapter 7. Nonetheless, the outcomes of such local developments could be observed at a nation-wide and a programme-wide scale of activity by means of documented reports and records of meetings.

People also forget the intricacy of details over time. This was brought home when I realised that my own memories at times skipped matters in documents that I myself had authored fourteen years past when working at CIVDURG. I realised how I, as an actor, constructed my preferred history of remembrances in light of later situations. I could only assume that others, contributing to accounts and histories, could be similarly constructive. It seemed useful, therefore, to first conduct a document-based chronological analysis, and only then 'flesh it out' with remembrances through interviews, unless it became convenient or there appeared no other options than to interview a large number of people who were involved in the formation of the NEP.

In 2003 I requested documents relevant to the development of the NEP from the Ministry of Health under the *Official Information Act*. I was sent the Ministry's complete file, covering a period from 1986 to 2003, with only several missing pages and names blacked-out. Yet as I later confirmed, this was not the complete set of documentary material. At least one crucial report was held 'off-file', due to having been commissioned by the Ministry from the ESR, a private Crown Enterprise, and accordingly treated as private rather than public information. When I discovered that this report had been produced, and requested it by name, it was duly sent to me but only after the permission of the authors had been obtained, showing that it is not a public document of a type that can be searched for in a public database. This episode illustrates how many more such documents could exist without a researcher necessarily being aware from general catalogue searches. The strength of a 'following' rather than a 'scanning' method of accessing records is clearly evident given such situations and the general interests of gatekeepers in maintaining their role by preventing easy public access.

I also received permission from the Ministry to access files relating to HIV/AIDS that had been deposited in the National Archives in 1993 by the previous Department of Health. I visited the National Archives and copied all documents referring to HIV/AIDS, needle exchanges, several AIDS TaskForces, and any other organisation shown in a rapid initial reading to have been connected with these subjects. I collected copies of several thousand documents, the exact number becoming meaningless after the first thousand. These document sources established what official

decision-makers would 'know' and find more credible as coming from their own authoritative files and official archives.

The archives of the Dunedin Intravenous Organisation (DIVO) from 1988 to 1995 were made accessible by its management. I had full access to the defunct Christchurch Intravenous Drug User's Resource Group (CIVDURG) archive. All the functioning peer groups had offered their resources to assist the research at the NENZ AGM in 2003. I was unable to take up most of these offers, though I hope to continue exploring regional variations in the peer group histories.

CIVDURG and DIVO have been somewhat comparable in both being located in the South Island, equivalently distant from the North Island where New Zealand's political centre in Wellington and the commercial centre in Auckland are found. Apart from the strong differences between each peer exchange, drug injecting patterns in the North Island can differ from those in the South Island. For instance, at the time of research, premixed liquid opiates were commonly sold in the North Island, but never in the South Island. Yet there are significantly different expressions and perceptions of IDU community between Christchurch and Dunedin, despite high mobility and frequent visiting. Neither a single site, nor a national average, capture such differences in IDU ethos and market logics.

CIVDURG and DIVO were better known to me and their archives more convenient to physically access. Other South Island peer exchanges, for instance in Nelson⁵⁹ and Timaru, were established many years later, and therefore could not inform the founding NEP period except through their absence. After I gathered a research subset of archival documents I studied documentary material from this convenience sample of founding peer groups, I read accounts published by those who were indicated as having made key initial decisions.⁶⁰ I then contacted other key decisionmakers. I continued to search for missing records by trying to locate the documents cited in those I had obtained. It seemed more effective and rapid to maximise my options by primarily focusing on resources that didn't need to be negotiated with, nor transcribed, nor had internal shifts in perspectives and interests once having been published.

Qualitative methods are notorious for producing unmanageable amounts of information. The actual documents and copies were chronologically ordered in filing cabinets. The references to these documents, along with the information from documents and interviews, were chronologically organised⁶¹ in a computer database.⁶² The virtual files were then thematically keyworded according

59. Unlike any other peer exchange, the Nelson exchange periodically goes into recess, then reforms, indicating a particular ambivalence in Nelson's cultural environment.

60. Because policy was strongly top-down, most officials had no significant decisionmaking options. The NEP operated during the early 1990s with very few official changes. I did not pursue later officials or politicians because of their greater interests in presenting a party line or defending personal records. I consider that decades need to pass before this problem of bias reduces to manageable levels, and by then memories seem less reliable.

61. I periodically reread the hard copy files looking for assumptions and absences in the link to the virtual files, since I was not exposed to these in chronological sequence, which means that later information established the conditions of understanding of chronologically earlier information.

to the internal referents and the connections that emerged from attempted explanations in memo writing. As gaps appeared in chronologies and thematic paradoxes emerged, they became expressed as research questions. For example, one key question involved the significance of a nation-wide strike that the peer groups of the NEP threatened in 2001. I did not know about this strike until I found it mentioned in the Ministry Archive. This incident led me to search the available records more closely for information about the degree and maintenance of regional cohesion, and the expectations held about input into policy among the peer groups.⁶³ Other information emerged from the ease or difficulties of access to such unpublicised, discrete material.⁶⁴

I attempted to capture as much cross-connectivity as possible by minimising any losses of information due to filtering and selection. The computer file was cross-referenced by means of substantial and thematic keywords. These keywords were my initial method for exploring and recording themes. As an analytical device, keywords work by trading-off between categorical accuracy and the convenience of minimising cross-references. Keywords captured all of the references, prioritised characteristics that appeared more frequently in the material, while drawing attention to what seemed unique or otherwise puzzling.

Each document reference in my database was also annotated with a brief memo with my immediate notes on this source. The content of these memos were not overwritten. Instead they were added to in separate sections whenever the source documents were reread. I regularly searched in depth for material relating to particular periods that had emerged as problematic or suddenly meaningful in some way. At other times I looked for patterns in work-lists of references I created from database searches on particular names and keyword combinations.

My keywords were initially taken from the title and abstracts or other self-descriptions found in documents. These keywords were elaborated as I read and reflected on the contents, environment, and ownership of the document at the time of its generation and when I sourced it in an archive. The keywords associated the documents by means of the names of people, agencies, countries, objects, programmes, principles, groups, and themes. The names acted as categories, or sets, including sets of only one element.⁶⁵ I used this array of information to generate descriptive

62. Microsoft operating systems and applications were not used, since confidential archival material was included in the file. I used a Macintosh laptop computer system. The writing applications were first Nisus under OS9, then Mellel under the OSX operating system. The references and keyword database was initially Papyrus, then Bookends.

63. The legal independence of the peer groups as individual corporate entities alongside the contrasting illegality of IDU emerged as a crucial factor that informed later tactics of proposing regional administrative blocs. This factor also promoted the mutual interdependence of the peer groups which led to a national federation instead of a reticulation of geographical territory within a hierarchical, top-down, funding-addicted system.

64. For instance, some is only accessible to qualified researchers, not 'lay' IDU, whereas peer-professionals are generally too busy to gather and analyse historical documents. Neither State agencies, nor peer group Trust Boards, have employed peer-professionals as archivists or researchers in any capacity.

65. For a discussion of relationships between mathematical set theory and ontology, with reference to social sciences, arts and religion, see Badiou, 2007: 23-48, and in general.

explanations through the logics and processes of writing. Such narratives attempted to produce precise accounts that combined descriptions of objects, incidents, events, and concepts in a provisional analysis of the NEP. These attempts increasingly required clearer specification of boundaries and causative mechanisms to emerge from the sequential event structure.⁶⁶

The key themes, connections, and processes that emerged were extended by questioning the constituents, consequences and significance of each. I wanted to explore the potential implications of alternative decisionmaking, alongside potential differences in significance due to location, and changes in significance over time. I accumulated information and located it in a chronology, aggregated the information by theme, and selected particular recorded occurrences as being demonstrably characteristic or causative. I retold⁶⁷ large amounts of sequential information as event sequences that were wider, longer, deeper, more meaningful, more relevant, more graspable yet retained their solid actuality. Such questioning and positing of causes identified key constituents, including turning-points,⁶⁸ social structures, individuals, lines of division, and lines of connection. This method required more engagement and reflective work than a pre-defined study, yet improved the scope and relevance of the analysis, gave greater confidence that gaps in the source material had been identified, and enabled the redirection of analysis 'in mid-flight'. These techniques usefully addressed the unpredictabilities of case research, where explanations that describe boundary conditions (Ragin, 1992: 5) must frequently rely on identifying patterns within and between the contingent aspects of unique, unpredictable occurrences.⁶⁹ Nonetheless, such occurrences are time-bound, and path-dependent, while also embedded as on-going opportunities and constraints in local networks (Tilly, 1997b: 45).

A known problem of interviews involves a desire by participants to protect the reputation of a programme they care about. When a programme is lauded, with reason, as spectacularly successful, then conflicts, failings and ambiguities become smoothed over to enhance the achievements and defend 'mistakes' (Altman, 1994).⁷⁰ Lichtenstein (1996: 444-448) offers a pertinent discussion of the difficulties of interview-based research on New Zealand policy communities due to the interests of officials in not remembering certain things. I have used Lichtenstein's material to complement my own documentary material. However, the documented role and goals of Dr. Meech, the Chair of the AIDS Advisory Committee, and later the Medical and Scientific Committee on AIDS,

66. See Büthe (2002: 487-490), Griffin & Korstad (1998).

67. This retelling is not reduction, more the opposite. Retelling enables a complex and long actuality to be grasped parsimoniously without losing the scope, grounding, consequences and ethics. But only if done with craft and art.

68. Most crucial were the health sector restructuring that exacerbated the difficulties of central monitoring and strategic development, the shift from entrepreneurial to managerial leadership of peer groups (seen in the collapse and replacement of the Christchurch peer exchange in 1994-95), the withdrawal of many pharmacists in the early 1990s, the consolidation and commercial enterprise of Needle Exchange New Zealand from 1994, and a threatened strike by peer groups in 2001.

69. See Sewell (1996: 247, 272), Abbott (1992b: 68).

70. Dangers: "of over-romanticizing the achievements of grassroots organizations, of accepting the triumphalist rhetoric which many organizations use about themselves ... to increase support and win political clout" (Altman, 1994: 167).

problematises Lichtenstein's account of the official aspects of the NEP developments (Lichtenstein, 1996: 421). This illustrates some difficulties of relying on interviews, especially with small numbers of decision-makers who have a strong institutionalised rationale to valorise previous policy shifts. Such valorisation tends to downplay the conflicts and uncertainties of the time, and diverts attention from the arguments of their opponents at the time. Consequently, I placed more confidence in accounts that included a degree of uncertainty and a range of perspectives.

The small size of New Zealand provides motives for policy and administrative elites to become more dependent, in terms of careers and socialising, on the good opinion of their peers than would seem the case in a larger society.⁷¹ This is why it was pointless for me to ask interview participants if they held a prior agenda for creating a needle exchange, let alone a peer-based form of an exchange system, or other interests. I assumed there may have been unmentioned interests, but not necessarily so in the case of any particular official. Nor did I assume that any collective interests of officials would be recorded in formal records, or that policy would not have been made by the administrative decisions of mid-level officials outside of recorded directives and frameworks.⁷² I was reluctant to rely only on insider accounts by policy-makers to explain how the NEP gained approval and status for an aspect of illicit activity. Instead I developed a more emergent, more widely explanatory account by prioritising written records with their greater scope, timeliness, and inclusivity.

Despite assuming the existence of distortions, researchers must explore the official records, since that record is expected by most participants to be accurate, is used as such in many everyday activities as well as legal conflicts in court, and accordingly enjoys both expert status and pragmatic acknowledgement, whether precise or not. I considered archival research to be appropriate, effective, and efficient provided that sufficient records from an adequate range of actors became available. Archival research also minimised the significant methodological problems of protecting researchers and participants when studying social ties that are illicit or otherwise secretive and stigmatised.⁷³

71. For instance, Redmer Yska's book on Wellington history (Yska, 2006) describes an official cabal, designated 'The Order of the Rabbit', sworn to self-interest at the expense of Councillors, loyal civil servants, and the public. After media publicity these rabbits ran for cover, unfortunately escaping extermination.

72. See, in general, various translations of Max Weber's original work on rational types and bureaucracies, (i.e. Weber (1947)), and its later complexifying by Lipsky (1980) and Giller & Morris (1981). The latter authors demonstrate how, in the US and UK respectively, low and mid-level officials in bureaucracies make policy and alter bureaucratic rule-books through their daily interaction with clients and non-officials. See also Merton (1957), Marx (1957), Hasenfeld & Steinmetz (1981), Smith (1981), Brown (1981), Zimmerman (1971), Hughes (1958). A careful summary produced in the mid-1980s, at the time of the AIDS Support Network (ASN) and AIDS TaskForce activities, is found in Ham & Hill (1984). These authors inform a long-standing debate on whether policy change is better understood as incremental and adaptive, or rational and either predictable or enforceable as a rigid model. These authors generally reject a simple typological framework, preferring to emphasise the ambiguous and changeable aspects, and so promote research through case studies, yet do not deny that institutions and rule-books act as powerful social forces.

73. See also, for instance, Fitzgerald & Hamilton (1997), Fitzgerald (1996), Broadhead & Heckathorn, (1994), Friedman (1993), Griffiths, Gossop, Powis & Strang (1993), Power & Harkinson (1993), Sterk-Elifsen (1993), Grund, Blanken, Adriaans, Kaplan, Barendregt & Meeuwse (1992).

I assumed that peer-reviewed information and accounts, or those sourced from state agencies, were generally precise, due to the costs of being caught behaving unprofessionally, or of deceiving those in relation to whom one has long-term dependencies, such as peers or voters. However, such accuracy could mislead if critical aspects of the criteria for measuring and reporting⁷⁴ were left out of the documented material.⁷⁵ I suggest that policy analysis is safest if treated as a game, certainly with rules, but also with rule-bending, and the likelihood of cheating.⁷⁶ Yet much social research can be characterised as cheating, since it ‘wins’ knowledge by circumventing legitimate systems that, formally or informally, keep information hidden.

From a rationalist perspective, the utility of a document lies in the degree to which it minimises or highlights gaps in knowledge. A document is an adjunct to knowledge.⁷⁷ From institutional perspectives, documents are so pervasive in organisations that they are apparently fundamental to its workings (Harper, 1997). Accordingly, documents as a ‘technological system of living’ might provide fundamental information about governance patterns, logics, and temporalities (Lash, 2001: 107-116). When I was working in the NEP I observed and participated in the production of many documents. I see more clearly now that they caused effects and were valued due to their activity as technological, mass-produced physical objects that travelled. I also see that these documents were formed in part through path-dependent bricolage⁷⁸ from that which was available as resource material, including understandings and goals, in their local environment.

Documents can explain aspects of developments through their going from and to certain places and people, but not others, in patterns of circulation (Campbell, 2004: 70-71). I read official documents in archives that peer-professionals actors working in the NEP at the time could not access, indicating how documents mediate trust and distrust (Campbell, 2004: 75-76). In Latour’s terminology, these documents were ‘immutable mobiles’, since they ‘locked-in’ and consolidated meaning in a centralising way, yet also multiplied and allowed control at a distance in mobile ways (Latour, 1990: 44-45). The NEP documents show how the authors and the actors participating in various types of stories were “able to make sense in the world” (Harper, 1997: 38), and thus embody social structures through a somatic sense of cultural boundaries (Bourdieu, 2004, 1991,

74. For instance, New Zealand police have planted evidence, as in the Arthur Allen Thomas case, attempted to obstruct or defeat the course of justice in the Dewar case (Kitchin, 2007: A1), and invented fictitious assaults on themselves, as in the 1996 Brent Garner ‘Executioner’ case (Christchurch Press, 2003: A8). New Zealand Immigration Department officials have been exposed for using e-mail to coordinate ‘lying in unison’. The records such officials produce cannot be assumed to be complete or precise, and may be intended to mislead.

75. In at least one case in drug policy history in North America, deliberate deception has been reported (Courtwright, 1982: 119-123). See also Lichtenstein (1996: 446) on the attitudes of New Zealand officials.

76. The likelihood of cheating is, after all, why rules are made. Within law and custom, what is proscribed is what is feared to be likely because it is desirable, not what is considered never to be a problem.

77. Documents provided self-description and contextual references to their physical circulation, including authorship, organisational affiliation, place of generation, destination, copies, and degree of privacy. Documents also provided narrative information about how the author expected to be understood, in relation to the problems that had caused a particular document to be generated, and kept.

78. Ad-hoc assemblage from a diverse range of constituents that were not deliberately planned and gathered, but instead are available due merely to chance. See Mackenzie (2003), Law (1987), Levi-Strauss (1966: 17-36).

1977).⁷⁹ My analysis does not treat documents as merely referring to information. Documents also embodied information in their textual and other structure, and in their movements that delineated links of communication, or if not, boundaries that limited communication.

Since the circulation of documents and sense-making can only be partial, not covering all places and people, every document is understood by those using them as partial and multiple, to varying degrees. Yet at the same time, people effectively use these documents to reduce the number of available ways of making sense (Latour, 1990), which helps to reduce their fundamental uncertainty when sense-making in a complex world. This is, after all, why documents are accumulated and archived in mutually supportive files. Any single document is dense with doubt, but I have also found surprising gaps in official archives. Some gaps are inherently authorial, since many perspectives and interests may not be recorded, due to the purposes that the document was intended to address, but which the document may not necessarily clarify. Other gaps can derive from the processes, technologies, and protocols of record-making. Further gaps may arise from how organisations selectively archived documents through both policy and chance. For instance, the National Archive's collection of the minutes of the National Council on AIDS does not include some papers recorded in minutes as tabled at meetings. Furthermore, its holdings end at 1991, yet the National Council on AIDS existed until 1993.⁸⁰

Reviews of the NEP over the period of the New Zealand health sector reconfiguration⁸¹ have also found gaps in the centralised record-keeping, where this existed.⁸² This systems failure has reduced the available documentary evidence; yet has also usefully illustrated the minimised, low-record, low-competency official environment in which peer-run exchanges developed their own 'professional competencies'. Neither state agency official nor peer NEP administrator could fully trust the latest documents, because the generation of documents was designed to plug or cover known gaps, while the documented information would contain unknown gaps due to selection and misadventure. In the research here I am assuming that known gaps are not critical. Yet I have borne in mind that certain records may be less informative because some contents or related documents or contexts are absent. This might come about if the document was the only surviving remnants of a series of documents that formed a 'sequential text'. Despite such provisos, I consider that the documentation I found forms a reasonably self-referencing 'whole', adequate for my approach.

I have not used a sampling method for gathering those documents and other accounts which linked

79. Bourdieu's projects overlap with Latour's, but in a competitive way. See Bourdieu (2004: 29).

80. National Archive staff could offer no explanation or other location for the missing minutes, as at June 2005.

81. During this period, community organisations were forced to devote their resources to generating funding applications in a competitive environment; managing the documentation of employees who had been volunteers before the passing of the *Employment Contracts Act (1988)*; and producing reams of reports on the outputs designated in funding contracts. However, little centralised analysis of community programme outcomes were evidenced at all (MacGibbon, 2002: 20-22, Lichtenstein, 1996: 416-419), let alone made available to community groups to facilitate their effectiveness and efficiency.

82. See Aitken (2002: 38-39), Fitzgerald (1995: 1, 12), Walzl (1994: 41, 44-46, 50-51).

to the NEP and HIV/AIDS and hepatitis C. Instead I have attempted to follow, gather, and engage with all the relevant source material, while acknowledging the limits on my resources and the contingencies⁸³ in the preservation or availability of my material. Although I have attempted to work symmetrically ‘even-handedly in the middle of things’, my ‘following’ methodology has led to greater access to documents than to off-the-record discussions with key participants. This means that undocumented influences, internal or external to New Zealand, could be under-represented in this analysis. Nonetheless, I am not inclined to attribute causes to covert influences unless in a situation involving only a few key decisionmakers, and where the attribution is corroborated by an intersecting range of sources. Unless putative secret influences can be brought into the public domain, for instance by being widely believed in and thereby causing overt, observable changes, they do not belong in a ‘social’ history. These aspects are murky,⁸⁴ yet I have attempted to cut through this fog by privileging the perspectives of participants on the ground and in the middle of things. Such research, and possible distortions, would have been unknown, or a standard background, to the IDU and NEP peer-professionals when they actually made their policy decisions. Having considered such uncertainties over the content and secrecy of information, I argue that the more forceful strands of the needle exchange developments have been echoed within this text through my presentation of a meaningful set of overlapping cycles, or folds, together with structural descriptions of the shapes of mechanisms.

My approach has been to first understand the local elements and environments before attempting comparisons. However, I accept that comparative analysis, while unlikely to be so deep and engaged within the available resources, could provide different perspectives, emphases, and models. For ‘straight’ policy analysis, incorporating an underlying assumption of essential similarities between different societies, comparison may be preferred, despite a tendency towards accepting ‘top-down’ information sources and perspectives. Yet for an actualist evidence-based social history, and for an exploratory rather than implementational or hypothesis testing goal, my technique seems adequate within my timeframe and resources. The criterion for this accounting for the force of the forms of repetitive sequences and structures lies in whether continuing research finds different key themes, forms, or forces to be more explanatory, or more precise. My account of this material on the substantive developments of the NEP is laid out in the following chapters.

83. I treat contingencies as discontinuous things that cannot be avoided, whereas structures are constructed and connected, whether intentionally or unintentionally. The eruptive urgency of HIV/AIDS and HCV is contingent.

84. The situation is further complicated by government interference in scientific research. For instance, the United States government is reported to have systematically distorted climate studies. Given the fundamentalist promotion of a war on drugs by the same government, I would not accept at face value any research originating from the United States, or from dependent nations or from compromised organisations such as the United Nations and the World Health Organisation. The difficulty in adapting this precautionary approach lies in the ambiguities over the relationships between New Zealand and United States governments. New Zealand is a military ally of the United States (Hager, 1996, 1995) yet New Zealand has also defied United States policy over nuclear ship visits.

2 Actor-network Approaches

In 2002 a quantitative comparison with equivalent Australian programmes reported that the NEP was “effective and efficient” (Aitken, 2002: 7). But in the late 1990s a sudden upsurge in New Zealand’s amphetamine use towards Australian levels had created a potential for injection to supplement smoking as a normal route of administration, as in Australia (Long, 2003: 2-3; Aitken, 2002: 21). If the numbers of IDU or frequency of injection increased, given that stimulants tend to be injected more frequently than opioids, the NEP would require extra resources to maintain its coverage and levels of service. Because the NEP’s initial user-pays funding structure was supplemented by a government funded, free one-for-one exchange system in 2004, increases in injecting drug use entail significant increases in politically sensitive public expenditure. The mechanisms and network effects of this situation illustrate a type of narrative logic that both contextualises and explains through description, for instance in showing how stories can inform policy consideration. Such stories can also explain relationships between events and effects in ways that include rather than exclude human agency, alongside the activity of objects.

When reading the archival records closely I noted how the medical professionals who offered advice on the prospective NEP frequently explained the social non-compliance of IDU in terms of a ‘natural’ biomedical problem of physiological and psychological addiction. Yet later medical professionals also explained the physiological ‘natural’ harms of HCV transmission amongst those imprisoned for drug offences, in prison sites where drugs were injected. The medical professionals did not explain this transmission as being physically and physiologically caused and similarly preventable. Instead, their explanation was framed in terms of the social responses by enforcement authorities to the inmates’ non-compliance with drug laws. The prevention of disease transmission was implied to be social, inasmuch as inmates who obeyed the law would not spread or contract HCV. Categories of ‘nature’ and ‘social’ were at times used to explain each other, in a way that evaded analysis of the network activity from which their mechanism emerged in accounts (Latour, 1999a, 1999b, 1993). This tactic highlighted the logics used in accounts to frame the status and meaningfulness of narratives.⁸⁵

The NEP participants experienced narratives as attaching to, permeating and enscribing objects in the process of arranging, making meaningful, and responding to the construction and movements of such objects. Objects, accordingly, told stories, and those stories informed my search for further information and the meaning of incidents. In seeking stories about stigma it happened that

85. Latour (1993) discusses the ‘purification’ of a messy reality into categories of ‘nature’ and ‘social’ which are deployed in a generally circular mechanism to explain and control the other. Emily Martin has critiqued such explanations of human-non-human interactions for being universalising in a manner which creates a privileged authorial voice which carries a privileged model of ‘normal’ social interactions, but in a disguised method (Martin, 1995). See Swyngedouw (2006), who follows Zitouni (2004), for further unfavourable (but less persuasive) comparisons of Latour to Haraway.

commercial discussions over the importing of syringes made more meaningful connections than surveys of the educational qualifications of IDU in treatment. Syringes, NEP workers, community magazines, drugs, and official documents were observed to engage with IDU in 'motivational counselling', and 'information gathering interviews'.

Appadurai argues convincingly that: "commodities, like people, have social lives" (1986: 3) and "circulate in different regimes of value in space and time [instead of being] inert and mute, set in motion and animated, where knowable, only by persons and their words" (1986: 4). According to Appadurai, this latter perspective:

does not illuminate the concrete, historical circulation of things. For that we have to follow the things themselves, for their meanings are inscribed in their forms, their uses, their trajectories. It is only through the analysis of these trajectories that we can interpret the human transactions and calculations that enliven things. Thus, even though from a theoretical point of view human actors encode things with significance, from a methodological point of view it is the things-in-motion that illuminate their human and social context. (1986: 5)

My actor-network method involved 'following' people, texts, codified moralities, money, viruses, technologies, syringes, and drugs. As I followed these actants, I paid attention to their 'shifts and translations' between sites of activity, especially the activity of preventing change. I noted how narrative objects were build up and out from such movements and connections. Actor-networks can include hybrid linkages of heterogeneous constituents, and are sensitive to stabilising effects created by circulating objects (Latour, 1999c: 71-74, 80, 98-112). From actor-network perspectives, objects, substances, and surfaces come from relational effects of the processes and trials of control, but are not essential entities 'in their own right'. These relational effects are without blame but are intensely political in being all about control. Such activity is followed more than defined, or sampled, or statistically represented and measured. This is because the most significant influences may be ambiguous, or dis-similar, or work through forms of contact rather than amounts and numbers. Because objects, such as syringes and packets of information, moved between sites, as if following or drawing a line, difficulties could be modelled as boundaries that crossed such lines of desired action. The difficulties could be grouped, since they derived from institutions, or from the interests of sets of actors, or were otherwise patterned. Since these difficulties were expected, the work required to overcome them was also expected, and was conceptually framed as such in the circulation of objects and communicative processes of translation I observed in the NEP.

Actor-network accounts typically follow the circulations of physical objects, and often identify stages of translations of meaning, for instance in policy documentation. The actor-network approach uses a 'minimalising'⁸⁶ methodology that is positive and interpretative, combining realist

86. Actor-network minimises through parsimony in accounts and explanations, not by simplifying complex arrangements or emergent phenomena.

and relativist aspects. The methods and explanations follow how objects move, or not, and object boundaries are stabilised, or not, in networked, rhizomal locales (Murdoch 1995: 747). These rhizomal environments of entangled links produce clearly observed activity and the solidity of object effects, yet the extended and complex enthreaded paths also produce uncertainty in the outcomes, categories and understandings.

Actor-network approaches differ from other types of analytical positivism by directly observing the emergence of solid effects within complex, messy systems.⁸⁷ In actor-network approaches, solidity and surfaces are not essential properties and not necessarily simple. Such approaches can achieve an openness to the unexpected, to the uncategorised, and to the counter-intuitive by restricting explanation as much as possible to close observation of what can actually be observed and interacted with. I used an actor-network⁸⁸ approach to my selection of sources, and was informed by actor-network sensitivities, along with related ethnographic immersion in the area of study, when configuring the resulting items and patterns of information.

Bruno Latour's actor-network approach promotes a general assumption of 'symmetry' prior to observation and analysis. Such symmetry is intended to destabilise the division of reality into categories of 'nature' and 'social' worlds, with different types of explanations whereby each, in its own field, assumes priority over the other. Latour's actor-network analyses do not accept such prior division into 'natural or social' except as a process of construction and normalisation. He problematises a sociology where 'the social' is privileged over 'the natural', or vice-versa. For one thing, such biases encourage an overlooking of the significance of material objects in how people live in and make sense in terms of a material world of substance, surfaces, and shape. For another, people seem more easily abused when labelled as 'natural' recipients of exploitative strategies. I considered that the stand-point of 'general symmetry' was suited to research with marginalised practices and people, such as IDU, whose stigma is intimately related to their use of restricted technologies involving forbidden substances. Such symmetry helped in empathising with the difficulties IDU needed to deal with, alongside the problems of reproducing from an assumed perspective of a virus, and gave greater confidence that stigmatised sources of information were not excluded by my research methodology becoming infected with a law enforcement agenda.

87. This contrasts with conventional positivisms that often rely on the reduction of complex systems into postulated causal essential elements and the prediction of determined events through postulated causal structures.

88. For actor-network style studies in networks of cyborg and object hybridity, often utilising case studies that follow or 'interview' objects, see Giere & Moffatt (2003), Haraway (2000a, 2000b, 2000c, 1997, 1991a, 1991b), Law (2004: 68-69, 151, 158), Lash (2001), Gomart & Hennion (1999), Bowker & Leigh Star (1999), Leigh Star & Griesemer (1989), Preda (1999), Harper (1997), Knorr Cetina (1997), Murdoch (1995), Rosen (1993), Law (2002, 1987), Callon (1999, 1991), Callon, Larédo, & Mustar (1997), Berg (2004), Latour (2004, 1999a, 1999b, 1999c, 1996, 1993, 1990, 1988, 1987), Gomart (2002a, 2002b), Pickering (1991). For a linking of my actor-network type approach to my historical approach, see Valentine (2007). For actor-network approaches related to health, see Valentine (2007), Lehenkari (2003), Mol (2002, 1998), Dugdale (1999), Moser & Law (1999), Willems (1998), Latour (1988). For actor-network linkings to institutional and boundary analyses in general, see Todeva (2001), Dellbridge (2003), Leigh Star & Griesemer (1989). For actor-network applications in New Zealand contexts see Doolin (2001), Doolin & Lowe (2001), Lowe & Roper (1997), Thom (2004, 2002).

In this thesis I am presenting a single approach, involving linked methods, for explaining both the well-delineated and the ambiguous aspects that contribute significant activity to the NEP case. My account draws on the surface ‘fit’ and connective relationships found in and between case narratives, actor-network symmetry, Deleuzian machinic assemblages,⁸⁹ hybrid models, and mechanisms.⁹⁰ This is because I value the way these approaches are positively described, are imaginatively open to the personal problems of individuals, and incorporate innovations alongside trials, or testing, of organisational arrangements. The research improves in internal consistency, parsimony, and coherency because the same approach has been used for the identification and analysis of source information.

I make no strong claim of predictability, instead using an abductive logic⁹¹ to argue for a ‘strong emergence’ (McLennan, 2006: 148) of a hybrid ‘peer-professional’ pattern that influenced the participant understandings that underlay the process of its emergence. In the final chapters I extend this descriptive material more retroductively⁹² by arguing that the NEP’s hybrid peer-professionalism best explains its overall capabilities. My argument builds on a theorised ‘as things actually happened’ historical account (Midgley, 2000: 177-178) involving an interplay of temporal and structural aspects (Conley, 1993: ix-xvii), found in stories embedded in complex, partial, and entangled sources.

In my account, forms of expertise and professionalism emerged through ad-hoc assemblages of heterogeneous constituents. Such expertise may be framed as forms of ‘cultural hybridity’ (Brown, 1997: 186-187, 190-194; Patton, 1997: xi-xx) or the activity of ‘cyborgs’.⁹³ Social living seems unthinkable and unworkable without the folding of material environs, physical objects, and organisational logics into shapes of expertise. For example, without a clinic, medical equipment, referral systems, and qualification regimes a doctor becomes something rather different. Doctors use instruments for the diagnostic and treatment practices that connect physically and informationally to patients and also funding agencies, producing an institutional configuration and cultural expectations of ‘satisfaction’. The bits and pieces seem to fit reasonably well and ‘satisfy’ each other. However, these specialised instruments for dividing and distinguishing expert labour into specialties and status are held together and kept aligned within networks of professional and official interactions. The significance of such a network view of striated knowledges lies less in the clear outline of any particular net, viewed as if frozen in its configuration at any point in time, and

89. For discussion on the operating and production of social-historical-ethical action through the relational modes of form and force, see Deleuze & Guattari in general. In particular, see *A Thousand Plateaus* (Deleuze & Guattari, 2004) and *Difference and Repetition* (Deleuze, 1994), also commentaries by McMahon (2005) and Surin (2005).

90. A model may be treated as a type, as in Weberian ideal types. I am cautious when dealing with ideal types because they are generally assumed to be more specific, with more assumed meanings, and with more associations with rational structures than cases, yet the grounded boundaries of cases seem more directly informative to explore.

91. See Appendix 9.3.

92. See Appendix 9.3.

93. See Haraway (2000a, 2000b, 2000c, 1997, 1991a, 1991b), Law (2004: 68-69, 151, 158).

more in the complexity of the articulated overlays, foldings, and shifting alignments (Murdoch, 1995: 754). Similarly, IDU as actors require mass-produced, dependable modern syringes and a reasonably predictable mass-produced supply of injectable substances. Without these materially embodied practices (Berg, 2004: 25-27) it is more difficult to assemble and articulate IDU social worlds alongside biomedical and industrial worlds. There are problems in the translation.

In actor-network terminology, 'translation' involves a process of reformulating and relabelling the goals and identities of actors through realigning their interests, boundaries, and connections. As will be outlined in chapters 4 to 10, actors in the NEP attempted to form coalitions to protect their longer-term interests. These coalitions mediated the presentation of public goals and identities. However, such long-term interests and tactics were also supported or destabilised by the associated, everyday activities that sustained actors in the immediacy of their positioning in local instances and connections.⁹⁴ The translational activity of realignment or the blurring of alignment was achieved through altering the connections that positioned particular assemblages as a local foreground, in contrast to a wider and more backgrounded heterogeneous network (Latour, 1987: 113-119). During these shifts, new combinations of actants generated new organisational assemblages, while previous assemblages changed in shape and size. This is my way of explaining through describing how IDU became included as participants in public health, in terms of HIV prevention, but remained excluded from public participation in terms of HCV prevention.

Translation methods have proven useful in analysing historical changes in the naming and policy consequences of regrouping networks of drugs, medicines, and infectious diseases (Moore, 2004: 422). Translation encourages analyses of how 'lines' of connection and boundaries become institutionally stable and productive by means of their difficulties, alignments, realignments, and trials. In this way, the topological analyses that emphasise shapes, configurations, and form become analytically engaged with the discursive analyses that focus on language, meaning, motivations, articulations, and forces. This type of actor-network engagement in processes of translation is characterised by its attention to the understandings and production of the effects of 'solidity' and 'sequences'.

When boundaries cannot be crossed, except through a single connection, whatever or whoever controls that connection actively shapes the local network. My analysis followed objects, such as syringes, across a topography of connections and boundary lines. In this process the existence of shaping conditions, such as constraints on the number and capabilities of the connections that created the effect of an obligatory passage point,⁹⁵ became more noticeable. The co-ordination of

94. The NEP activities were required to be meaningful by officials and managers in the short-term, in order to achieve HIV/AIDS prevention in IDU networks, which had become required to sustain longer-term interests of protecting the public health of non-IDU.

95. 'Obligatory passage point' is a classic military, political, and hunting mechanism used to explain causal processes and descriptions of contingencies in actor-network methods. See Callon (1999, 1991), Callon et al. (1997), Latour

different types of multiple elements into regular circulations, and the problematisation of why other circulations did not happen, offers an analytical framework wherein meaning-making follows syringe movements. Because people have been key agents, although not the only actants in such circulations, an actor-network perspective pays attention to how subjective perspectives have been framed in narrative accounts.

Actor-network methods resist prior categorisation and query the boundaries of entities by inherently destabilising authoritarian principles of an 'essential' status-quo. By contrast to a 'black-boxed' normality, defined, categorised and deployed according to the needs and conveniences of elite groups, actor-network approaches are a type of critical non-theory, or praxis.⁹⁶ These methods encourage analyses of the actancy of power, and of the ways in which various boundaries of authority become more or less sustainable. Since actor-network methods emphasise the need to follow the details of everyday reality, without overlooking the production of power and pain in the pursuit of dreams and dependencies, these methods are well-suited to exploring the conjunctions of drug-using and democratic processes, where the citizenship and public voices of drug users are put on continual everyday trial. The ways in which substances and technological devices, such as drugs and syringes, are intertwined in such voices and questions, are usefully integrated by using actor-network methods of following movements, boundaries and translations.

3 Following sources and stories

My sources were found wherever I followed the temporal, structural, embodied, and narrative factors that the participants of the time reported to be relevant and significant. I also analysed the constitution of network effects in the case, using such effects as a guide for looking for sources of information that compared with the case, or which clarified wider contexts in which the case was situated. This approach maximised my responsiveness to the patterns and scope of the environments being studied by minimising the categorical baggage of prior theorising. The

(1988: 43). Immergut (1992) uses a concept of 'veto point' when analysing historical conflicts between European medical professions and state agencies. She argues that decisions were shaped through the institutional configurations of decision-making. Immergut demonstrates the significance of national differences in decision-making processes, especially the number and type of veto point for blocking proposals from being enacted (Immergut, 1992: 226-228, 233-234, 241-244). Immergut's policy veto points may be understood as obligatory passage points formed from an interplay between process boundaries and institutional boundaries that make a veto point obligatory. Her approach problematises explanations based on universals. I initially considered using 'veto point' explanations but found the scope overly restricted to policy domains that did not adequately engage with objects, stigma, and professional culture.

96. In Ancient Greek usage, praxis (πρᾶξις) referred to activity that was engaged in by free men. For instance, Aristotle categorised praxis, along with theoria and poesis, as the three basic activities of man. Three types of knowledge, or knowing, corresponded to the three types of activity: theoretical, where truth was the end goal; poietical, where production was the end goal; and practical, where action was the end goal. Aristotle categorised practical knowledge even further into ethics, economics, and politics. Modern usage of praxis may refer to activity as informed by theory, which is not an actor-network approach, but also to activity as informed by models and skill, which is somewhat actor-network. A specific actor-network praxis includes activity of meaning and communication informed by physical activity and by objects.

approach initially assumed a methodological ‘symmetry’ by refusing to prioritise or exclude different types and sources of accounts. These methods and associated criteria explain how my selection of source material came to be rather wide.

From 1989 to 1992, and from again from 1994-1995, I participated in the NEP operations while considering how the movements of syringes might be improved. Later, after having studied material cultures and actor-network analyses of ritual, science, and health care, I considered that an object-focused approach was needed for exploring a programme that was centred on syringes and on the subjective motivations of syringe-users. Given that I wanted to understand how capabilities emerged and remained sustainable, I also considered that a method of describing temporal events was needed. These considerations combined in an argument for using narrative methods to analyse how stories associated and de-associated with other stories, along with objects and people.

Stories emphasised the way information was only to be found in patterns that were embedded in conceptual contexts and material objects. This implied that finding information required observing and following objects, while also following narrative linkages between the material, cultural, organisational, and personal elements that constituted the networks of the NEP case. In actor-network terms, these elements have been interactionally actual and meaningful because they exhibit an observable material semiology (Law, 2007), where “what it is depends on what surrounds it” (Culler, 2007: 10). A general framework of case analysis seemed to overlap usefully with these network methods, since the case, narrativised as a diachronic social history, could be explored using the potential alternatives and actual closures of synchronic network effects.

I could make this approach work because I had participated in these networks, experiencing them, with an immediate grounded focus at the time, from an insider’s perspective. Furthermore, during the course of the research I continued my habit of carrying safety containers at all times to dispose of the syringes I find on occasion in public places. This practice, which risked harassment and arrest, allowed me to directly measure my own motivations and distrust in terms of the benefits and costs of association with used syringes. Both the remembrance and the ongoing direct experience supported my decision to adapt an actor-network approach.

Actor-network methods have worked well in other case-specific approaches where prior theorising and prioritising of sources has been deliberately minimised in the interests of escaping a priori formulations. This approach attempts to avoid a formulaic type of conceptual generalisation⁹⁷ which both prescribes and precedes the research information. I consider that formulaic approaches have no place within a grounded, actor-network case study. This is because the motives of illicit participants are more likely to become objectified as exceptional, whereas they need to be subjectified as normal. Furthermore, a formulaic approach risked encouraging conventional

97. The issue of generalisation is deeply embedded in the philosophy and history of science (Kuhn, 2000, 1969).

prescriptions and moral attitudes to drug use to become the complicit and singular goal of the research, instead of valuing and offering stories of alternative goals alongside descriptive stories of actual effects and events.

I do come to generalise my analysis, but mostly in a case-informed, reflexive way in my final chapters. There I explore how a general principle of the organisation of the NEP relates to the case-specific aspects established through my actor-network approach. Nonetheless, I do not simply start in the middle of the case, since social science accounts require detailed descriptions and justifications of methods, even if these are theory-averse, in advance of the narrative methods of describing observations and conceptual framings. I point out that although requiring permissions from gatekeepers, all the sources of my key information are named and accessible to peer review and future research. From the perspectives of both arts and sciences, my criteria for selecting sources constitutes a major part of research credibility. Actor-network methods add to the significance of sources, in relation to criteria, because the sources are ‘the thing itself’, undistanced yet always in the midst of critical translation.

When I began my analysis, the historical type of case study seemed capable of holding together, as a meaningful account, the then seventeen year duration of the NEP developments. I later came to consider the NEP’s sustainability as constituting a case of a particular type of exchange activity, as well as being a shaping of institutional expectations. Even later, I characterised the NEP case in terms of its inherent antagonisms that stabilised a uniquely semi-licit yet ‘solid’ occupation. As I describe in the following chapters on social history, the NEP case has featured cycles of repeating patterns of developments. This cyclic aspect raises questions about the relationship between descriptive and explanatory accounts of the similarities, and the boundaries, of these distinctive cyclic periods.

The question of boundaries is always critical to case analysis. This is because the content, character, processes, and exterior of a case are inherently matters of boundaries, whether selected by a researcher or identified from observation, or through some other analytical method. I argue that my analysis of a mechanism, formed by associating and disassociating boundaries of temporal duration, expectations, and occupations, is appropriately configured as a case analysis. Moreover, single unique cases need to be explored by following the strands of internal cohering activity alongside the boundary processes that distinguish the internal aspects from external environments. My sources have been found along a branching network of research trails, or strands that intersect with the movement trails of actors, actants, information, laws, and logics⁹⁸ of distrust.

98. A logic in this sense is not a proof or a truth claim in the sense of the deductive and inductive processes. Instead, such logics provide a description of an environment with reference to the rationales that seem to make sense due to the features of that environment. An environment of distrust features institutionalised distrust alongside participants feeling that it is sensible and generally necessary to distrust, though not obligatory. The participants are assumed to be unclear about distinguishing between what they may do, and what they must do. Whereas a conventional

I consider that the interplay in case research between convenience sampling and following topical strands is valid in itself, yet is also justified by the problems of establishing the representativeness of sampling, or other methods of reducing the quantity of information while constructing representation.⁹⁹ Such problems seem greater than the problems of integrating an excess of information, given that source material has been restricted by the limitations of record-keeping and would be hazardous to reduce further. My methodology depends upon gaining access to sources of information, balancing my engagement as a partly-inside, partly-outside participant, while integrating the significance and consequences of theoretical frameworks.

The linkages and meanings I present make more sense in part because they make sense to me. I have incorporated part of my story in the account offered in this thesis, because I was there, because this was important in my approach, and because, since I was active as the presenter and gatherer of stories, to suggest otherwise would be misleading. Yet I intend to portray the character and capabilities of the NEP rather than an autobiographical account:¹⁰⁰

Like every aspect of portraiture, voice is imprinted both on the product - the portrait as a finished narrative - and on the two mutually informative aspects of the portraiture process: the collection of data and the analytic shaping of the final portrait. ... the methodological question that portraitists must repeatedly ask of process is How (to what extent) does the disposition of my voice inform (give shape to but not distort) the product (the developing portrait)? And ... How (to what extent) does the articulation of voice inform (clarify but not mislead) the process (the developing understanding)? (Davis, 1997: 106)

As Davis emphasises, my understandings of linkages, frameworks, boundaries, and meaningfulness are significant. These understandings require specific explication to distinguish between a self-portrait observed only by myself as alone, and a more descriptive actor-network case account observable by many.¹⁰¹ I have tried to address this difficulty by laying out the configuration of my research logics in this and the following chapter.

I ask myself periodically if my exploratory and representational methodology is particularly sociological, rather than an example of history, cultural studies, anthropology, critical management studies, or investigative journalism. All of these disciplines can produce effective social science, in the sense of producing analyses that are evidence-based, rigorous, and comparable with alternatives.

Austrin & Farnsworth point out that there are: “diverse tensions out of which the hybrid formations

mathematical logic, as in deduction and induction, is a tactic to achieve greater closure and stability of categories, a social logic is unstable and resists closure. This makes such social logics of institutions and an ethos of distrust suited to the groundedness of an actor-network following approach.

99. A sample does not, merely of itself, represent a group, but rather is posited and calculated as doing so. Such selection and calculating cannot be done without first constructing the boundary relationship between the numbers of case incidents, and the overall single case which contains these numbers through a qualitative relationship. Only the single case is sampled, not any particular incidents, since these are unique before being reconstructed as a group.

100. Despite my own life course being somewhat peer-professional, as no doubt are many.

101. It is acceptable to only perceive things through the medium of a researcher's work because all things are only understood through the work of various creators and maintainers of perceptual frameworks.

called “sociology” were forged” (2007: 53). This is important for two reasons. First, labels aside, the differences between these disciplines are those of methodology and goals which are in a tensive ‘tug of control’ with those of the sociologies.¹⁰² Second, there are many sociological formations, which in being hybrid, may strongly overlap and mutually influence the hybrid assemblages of the other disciplines I mention. I cannot here explore this case of disciplinary boundary work because I dedicate my argument to the NEP case, but I can offer a succinct response in several parts.

An institutional answer is yes, due to the significant body of sociological literature I have drawn on and added to, this is indeed sociological research. A more sociological answer is yes, this is sociological work, due to my sociological methods of engagement and abstraction, of relationality and reflexivity, of connecting personal troubles with social issues, as well as relating strategic agency to the structuring and sequencing of tactile and textual social environments. I formally relate the NEP to my argument through the levels, relevance, and scale of my theoretical framing of structural boundaries and the periodising methods of social history.

According to Mills (1959), a core criterion of social analysis consists of a ‘sociological imagination’. Mills argues that personally experienced problems become better understood and more capable of analysis through an enhanced awareness of historical and structural patterns. The emphasis I place on the ‘capabilities’ and the equivalent standing of actors’ accounts suits an abductive,¹⁰³ constructive logic. Abductive methods of analysis acknowledge the significance of personally experiencing problems and opportunities such as those that have permeated the NEP. The NEP’s methods and principles can also be provisionally and cautiously generalised from the multiple elements of a single case study by using inductive processes of descriptive explanation and accumulating the instances or events which were similar. My research approach involved first an abductive approach, then a retroductive approach to following evidence trails left by participants while generating this analytical narrative. Inductive, abductive and retroductive elements have been gathered and aligned within not so much a narrative logic, but a logos. The resulting account has explored the NEP’s mix of singularity and generality in an interweaving of science, craft, and art¹⁰⁴ approaches. My particular approach to articulating objects with stories in the production of an analytic narrative text is described in more detail in the following chapter.

102. For example, sociology in New Zealand has been characterised as under pressure to function as a service department to other disciplines (Austrin & Farnsworth, 2007). Sociology internationally and historically has acted as “a parasite, ingesting and metabolising other disciplinary discourses”, according to Urry (1981, in Austrin & Farnsworth, 2007: 47) yet in consequence “destabilises its capacity to function as a unitary discipline itself” (2007: 47) while featured an “inability to resist intellectual invasions” (Urry, 2000: 55).

103. I used Blaikie’s version of abduction as a: “different logic to the other three [inductive, deductive, retroductive]. ... The starting point is the social world of the social actors being investigated: their construction of reality, their way of conceptualising and giving meaning to their social world, their tacit knowledge. This can only be discovered from accounts which social actors provide. Their reality, the way they have constructed and interpreted their activities together, is embedded in their language. Hence, the researcher has to enter their world in order to discover the motives and reasons that accompany social activities. The task is then to re-describe these motives and actions, and the situations in which they occur, in the technical language of social scientific discourse.” (2000: 25).

104. By art I refer to a uniqueness of perspective and the deliberated construction of social sensibility.

Articulating stories, objects, analytical narratives

I rely on a kind of relentless insistence on the non-transcendent, on the always being in media res, that life is a verb and that the actors aren't all human. There are very important nodes of energy in non-human agency, non-human actions. ... So I am trying to find descriptive languages that name emergent ontologies. ... The world is in the details. ...

(*Birth of the Kennel: Cyborgs, dogs and companion species*. Donna Haraway, 2000c)

I have indicated in the previous chapter that I pay equivalent attention to objects and stories and that I analyse the activity of stories as empirical factors. It will be clear why objects are significant in research focused on syringes, but why are stories so important? For one thing, objects such as syringes have been widely distributed, at times fast-moving, making them difficult to follow directly. They were also used and understood differently in different situations, which a researcher may not gain direct access to but were partially experienced through stories that a researcher can potentially access. The character and meanings of syringes, particularly in the past, would be difficult to capture in static samples for concentrated analysis. Stories provide ways to 'translate'¹⁰⁵ and condense wide distributions of quasi-objects and their information into tighter comparisons and configurations (Latour, 1999c: 47-64). Moreover, stories can exert direct influence over collective organising because actors understand their desires and constraints in terms of the stories that they link to other stories in forms of logic, legitimations, and co-ordinating group activity.

In this chapter I prepare a conceptual space for the following social history and thematic chapters by laying out my key actants. These included the syringes, people, and documents that shifted around and within this case area. This information was generally enscripted in objects and embodied in people and viruses. However, this information was specifically configured as the stories that held together the historical accounts, reviews, departmental papers, academic analyses, remembrances, and media coverage. My analysis has engaged with the stories from which the NEP was constituted, and by which it has grown, in successive folds. My account relates these stories, understood as time-shaping narratives, to the NEP case in a process of unfolding chronological layers then refolding as a mechanism with a 'shape of activity'.

These logics and stances lay the foundations for my evaluation. In my first section I support the relevance of my analysis by outlining the strengths and deficiencies in previous accounts of the NEP, noting the contributions to my own work. In section 2 the academic literature on connected HIV/AIDS developments in New Zealand is outlined. I show where stories about similar problems and opportunities, in contexts of direct linkages with the NEP, have contributed to my account.

105. Translation is used in an actor-network sense of altering a set of linked entities from one state, to another that is treated as equivalent but is not identical. The resultant state includes the agency and network linkages of the translation process and entities. The linked entities often include meanings, policies, understood problems, interests, protocols, and objects such as documents. See previous description of quasi-objects, and Latour (1999c: 311).

1 Accounting for the NEP

Since I wanted to construct a social history of the NEP, I followed connections between its internal accounts and those of different HIV/AIDS related organisations and researchers. Only two overtly narrative histories of the NEP have been published, both by Kemp (2004, 1996). These were not highly theorised, nor thickly described, the latest being an article and the earlier a single chapter in a book on New Zealand policy responses to HIV/AIDS (Davis, 1996). They have, nevertheless, offered a singular, coherent narrative outline of a case (Maoz, 2002: 163, 170-171). No theorisation of hepatitis C policy, or related organisational developments, have yet been published in New Zealand. I have also searched the wider literature for general accounts of needle exchanges in order to understand the field better, and to follow any theorising back to their cases.

There is New Zealand and worldwide literature on AIDS-related shifts in cultural attitudes and media framing. This is important for illuminating contexts, but in general, does not reveal the mechanisms of policy shifts and the emergences of new practices. I found a number of official reviews of the NEP, and prior theorising on HIV/AIDS policy responses has produced a range of useful accounts. These accounts indicate that New Zealand responses to HIV/AIDS were led by political, professional, official, media, and religious leaders, since I found no body of material from popular mass movements or well-organised pressure groups outside of those most directly at risk. The absence of documents suggested the significance of charismatic leadership, uncontentious official influences, and marginalised sub-populations.¹⁰⁶ These accounts included stories about how the NEP developed and was understood, but for my purposes, did not adequately link the allocation of agency, conceptual frameworks, objects, contexts of motivations, infrastructure, and outcomes of policy intervention.

By 1996, New Zealand researchers had generally agreed that at least three major phases were involved in the organisational responses to HIV/AIDS. In one account, these phases led from grass-roots community organising to corporate institutionalisation, then to further professionalising (Lindberg & McMorland, 1996). Such analyses drew on international research,¹⁰⁷ and were primarily informed by the New Zealand AIDS Foundation (NZAF) developments. Researchers such as Lindberg & McMorland (1996), have analysed the relationships between the NZAF and state agencies in terms of policy responses to the challenges of HIV/AIDS, but less so as an example of organisational and occupational innovation. These analyses and examples may be approached more as singular definitive accounts, or alternately, more as stories where multiple versions are not inherently troublesome. The range of different perspectives found in these stories

106. This silent accounting for risk contrasts with moral panics, for instance over recreational substances in response to perceived cultural and economic threats. The exceptional case of a young white child refugee dying of AIDS (Lichtenstein, 1996) illustrates a general tendency to follow expert direction.

107. The three phases overlap with a wider international analysis of three or more policy response phases.

draws research attention to a 'negotiated case' of reality being constructed as institutions, as historical accounts, and as an archival selection process.

The multiple stories in the NZAF account (Lindberg & McMorland, 1996) were presented as a single case and as a single explanatory principle. This case and principle involved specialisation through centralisation, which included shifts and uncertainties in the activity and policy input of regional groupings. The NZAF account seemed to downplay antagonisms rather than attempt to use them in its analysis. These stories intersected with the official accounts of the NEP. The evidence for multiple actors and notably different perspectives within the NZAF account suggested deficiencies in the circumscribed range of actor perspectives and principle of consensus that have been conventionally used to explain the NEP. On following closer to the sources, it turned out that the conventional NEP account was unduly circumscribed. Furthermore, the NZAF stories set up the stage for the later NEP stories which overlapped before partly separating. The NEP itself specialised as it centralised, though in a quite different, bottom-up type of infrastructure. The NEP specialised into a pharmacy-based form of service provision, at the same time as it centralised into a single nation-wide programme and a single legislative framework. Yet unlike the NZAF, the NEP did not consolidate into or otherwise easily and quickly give rise to a single nation-wide corporate entity that managed professional service delivery. My participant experience with the NEP offered a more intense story of distrust that configured connections and boundaries between key sets of actors. This story provoked a search for aspects of distrust, such as assumptions and activities, in archival documents from before the founding of the NZAF.

In some ways an 'account' seems unduly singular and fixed in its boundaries, whereas a 'story' is more easily conceived as partial, multiple, and less fixed. When approaching a case by assuming its boundaries are unfixed, and only then checking to see how fixed and unfixed is the activity of different bounded areas, it seems more useful to work with stories than accounts. As I use these terms, accounts attempt to be definitive in their explanations, whereas stories attempt to be revealing by prioritising differences, often implicit, in goals and methods. Accounts, accordingly, tend towards fixing boundaries and singularity, whereas stories problematise boundaries as being partially fixed, partially unfixed, and intriguingly unpredictable. Of these two different goals and methods, I have looked into accounts to highlight rigidities and absences, and associated stories to provide the flexible connectivity that holds together this case and its study.

Many stories drew on a concept of consensus, generally not explicated, leading to continuing partnership, generally not infrastructurally detailed, as if 'consensus' was a causative force (Webster, 1990) rather than an effect of other processes. A more detailed and critical version presented consensus as a conventional tactic that preserved a 'policy making community' from the destabilising effect of public demands.¹⁰⁸ An unusually analytical story was of a consensus that, in

being constructed as a strategy, was “dense with contradiction” (Plumridge & Chetwynd, 1994: 294), and so was vulnerable to unravelling once AIDS was less feared due to the very success of such strategies. This story queried the way the NEP had grown rather than come apart. There was a story of simultaneous conflicting demands which had to be continuously met by organisations that delivered needle exchange services (Matthews & Leland, 1990). This story queried forms of discretion, understood as a form of trained expertise, in accomplishing such balancing, and led to questioning the backgrounds and training of the personnel involved in the NEP. One story featured syringes which circulated between different worlds, thereby providing an instrument for inspecting IDU and evaluating interventions in drug markets¹⁰⁹. I found a story of HIV/AIDS policy being exceptional, not only in being an emergency response, but also in the way it differed from HCV¹¹⁰. Another story was of grassroots organising being a cause deserving of loyalty, yet capable of betrayal, depending on the options chosen in pursuing health goals (Altman, 1994: 162).

Despite e-mail contacts with overseas NEP and harm reduction activists, I have not found any international studies of needle exchange developments in situations directly comparable to New Zealand's isolated and unique environments of policy and practice.¹¹¹ Furthermore, there are significant cultural differences between mainstream societies in the UK, North America, Europe, and New Zealand. Since IDU interact with mainstream cultural attitudes, especially via health services, it is unsafe to presume that research from these societies is directly applicable to New Zealand situations. I did not in any case consider that prior theoretical framings suited the emergent patterns and ‘storied meanings’ of an actor-network case study. However, I wanted to obtain any information about the New Zealand NEP gathered by overseas researchers, since that might cover gaps that I assumed would later remain in the New Zealand archival records.

An external review (Aitken, 2002) of the NEP provided useful information, but raised questions about why such a useful account had not been available earlier to inform the management and strategy. Yet this review's stories, methods, and goals were not prioritised towards understanding why the NEP capabilities had begun and changed, but rather to evaluating the costs and benefits of the NEP as a health and financial intervention. This goal did not prioritise or explore the character of the NEP, nor its shifts in operations, nor its cultural and infrastructural consequences. The review outlined the shape of several absent stories, or stories of absence, that wove around the history and priorities of the policy environment through which the review emerged.

108. See James (1992, as cited in Gauld, 2001a). See also Day & Klein (1989), Fox, Day, & Klein (1989).

109. See Kaplan (1994, 1991), Kaplan & Heimer (1994a, 1994b, 1992a, 1992b), Kaplan & O'Keefe (1993), Kaplan & Soloshatz (1993).

110. These soon exceeded projections of HIV/AIDS costs. See Crofts & Brown (no date, as cited in Kemp, 1996: 165). For costs of hepatitis C in New Zealand, see Sheerin (2003), Sheerin, Green, & Sellman (2003, 2001), Easton (2002), Chapman et al. (2000), Nesdale, Baker, Gane, et al. (2000), and Brown & Crofts (1998).

111. Many overseas studies are of situations involving ‘street scenes’ where purchase and injection happen in public or semi-public places as drug markets allow. This has not been the norm in New Zealand. Drug purchases and injection have generally taken place in private houses where some of the participants live, and locally grown poppies create a seasonal pattern of recreational, non-addictive injecting of chemically treated poppy latex.

Most studies of needle exchanges have tended to analyse and characterise needle exchange programmes quantitatively, in terms of short-term interventionist aspects of their operation.¹¹² These studies have largely been conducted in countries where the cost of NEP programmes have seemed less constraining than in New Zealand. Their arguments have been centred on effectiveness and consequences. In the United States, where harm reduction concepts have not been formally acknowledged at the highest government level, many studies have focused on whether harms to IDU and the general public might actually increase due to supplying syringes. Such concerns have been irrelevant in New Zealand contexts since 1988, when the NEP began operating without such problems appearing. However, early overseas models from Europe, the UK, and Australia influenced New Zealand policy responses and programme design.

I read studies with caution because their methodological assumptions were frequently buried beneath scientific jargon, their goals were often unrelated to the perspectives of officials and IDU, and their institutional resourcing seemed likely to constrain their possible conclusions. There have been, for instance, pressures by the US government on researchers, other governments, and NGOs to make HIV/AIDS funding dependent on promoting abstinence, on de-prioritising barrier methods of safe sex such as condoms, and on denigrating needle exchanges.¹¹³

Actor-network methods, along with types of analyses that delineate the working of mechanisms, have emphasised the following of everyday reality in the detail of its material and relational processes. These methods do not overlook the production of power and pain in the pursuit of dreams and dependencies. Such methods are well-suited to exploring the conjunctions of drug-using and democratic processes, where the citizenship claims and public voices of ‘normal’ illicit drug users may induce ‘abnormal’ social panic. The ways in which substances and technological devices, such as drugs and syringes, are intertwined in such voices and questions, is usefully integrated in actor-network methods of following movements, boundaries and translations. When such actants are observed to cohere in places, somewhat similar to how strands may cluster and fold into a knot, I describe the regular activity and the contours of such nodes as partial and provisional ‘mechanisms’ that nest within and help to constitute wider heterogeneous networks.

The mechanisms I describe are local and relational, positive, well-evidenced, yet unpredictable and complex.¹¹⁴ They include unique and discontinuous constituent elements. They do not imply or

112. For accounts of European syringe exchanges, see Buning et al. (1986). For early syringe exchange in UK environments, see Stimson et al., (1991), Hart et al. (1991), Hart et al. (1989), Stimson (1989) and Marks & Parry (1987). For syringe exchange in North American environments see Guydish et al. (1998), Guydish et al. (1993) and Weiker et al. (1999). Friedman et al. (1987) and Price (1992), briefly discuss the self-organisation of IDU in North American environments. For an excellent historical overview of the medical and policy environment in the US and the UK, as part of a general history of substance use from the 1600s to 2001, see Davenport-Hines (2004: 338-383).

113. See Ahmad (2005), Barnett & Parkhurst (2005), Das (2005a: 263-264, 2005b), Pancevski (2005), McKee & Coker (2003: 1580).

114. For methodological considerations of positive science, interventions, boundary work, observation, and positivism see Midgley (2000: 2-7, 11-14, 29-30, 34-44, 89-91, 113-133 162-168, 179-181), Crotty (1998: 18-74).

require a reductionist, mechanical ontology. Such mechanisms fit with Tilly's category system of mechanisms, models, and story narratives. Tilly considers that descriptions of structural interactional processes are most specifically presented as mechanisms, most generally understandable when translated into narratives, with models somewhere between these extremes of precision and accessibility (Tilly, 2002: xii-xiii; 1997: 6-9). However, I differ from Tilly in placing greater significance on stories and narrative because it is through information that the elements of mechanisms become aligned and activated. The more competent explanations need to approach mechanisms and stories even-handedly. Nor can narrativised information be avoided in a mechanism-based explanation, since explanations, legitimations, and directives are essential elements in any mechanism of social interactivity.

I looked for models related to the NEP, and found two, one an absence and one actual. The latter is an international set of models¹¹⁵ used in 'centres of calculation' (Latour, 1987: 229) to estimate the outcomes of offering HCV treatment to prioritised sets of prospective patients. Latour uses the term 'centres of calculation' to draw attention to the way calculations do not happen everywhere, at all times, universally, which a story that promoted statistical validity might claim. Instead, calculations with their frameworks, prioritisations and parameters happen at particular places and times. Since HIV prevalence among IDU rapidly decreased to effectively zero after the NEP began, it seemed understandable that higher priority might be given to other problems and that no specific models and calculations would appear in reports. Nonetheless, IDU exhibited a consistently high prevalence and incidence of HCV, which drew attention to how HCV has been treated differently from HIV, with particular reference to the centres and ethos of calculation. I searched for models of HCV epidemiology that related to alternative treatment strategies. However, no such published and specified models in general use and publicly accessible in New Zealand could be clearly identified by experts in this field (Sheerin, 2007. pers. com.; Jang 2007 pers. com.), or found referred to in any published New Zealand policy papers.

One model of calculation that directly influenced the NEP developments in New Zealand was a US model of syringe circulation. A research team studied unlinked syringes returned to a needle exchange and found that the circulation of syringes as objects enabled forms of non-voluntary monitoring.¹¹⁶ Phrases such as "behavior of needles ...[and] ... interviewing the needles" (Kaplan & Heimer, 1994a: 567-8) were emphasised. These themes presented the US research stance within a highly constrained and seemingly normalised research environment where IDU themselves could not be directly engaged with. I linked these research attitudes, methods, and findings to my general

115. See Hutchinson, Bird, & Goldberg (2005), Griffiths & Nix (2002), Bekkering, Stalgis, McHutchinson, Brouwer, & Perelson (2001), Deufic, Buffat, Poynard, Valleron (1999). See also a related account by Tacke & Trautwein (2007) responding to Amin, Law, Bartlett, Kaldor, & Dore (2006), Bernstein, Kleinman, Barker, Revicki, & Green (2002).

116. See Kaplan & Heimer (1994a, 1994b, 1992a, 1992b), Myers et al. (1993), Guydish et al. (1992), Heimer, Kaplan, & Cadman (1992), Heimer, Myers, Cadman et al. (1992), Kaplan (1991). More conventional research was carried out in South Florida by Chitwood et al. (1990), and in Sydney by Wolk et al. (1988).

actor-network approach, then extended my literature search to see how this method and information had influenced other researchers. Several UK researchers had commented critically on the way in which the US study had 'interviewed needles' in preference to engaging more fully with the IDU participants.¹¹⁷ The 'voices' of syringes seemed to be constituted in part from the orchestrated silencing of the syringe users, not necessarily by the researchers directly but by the system within which the research took place, as I will show in detail later.¹¹⁸ This US study model was drawn upon in designing a study carried out by a Wellington peer group (Kemp, 2004).

Several Australian researchers (Wodak, Dolan, & Imrie et al., 1987) had suggested analysing returned syringes, in an implicit story of the precedence of public safety over privacy. As I will later describe, this was followed in New Zealand by the actual testing of the syringes in different situations of informed consent. Testing without full consent emerged as a story of cultural exchanges and trust, or distrust, between the criminalised and medicalised jurisdictions generally associated with enforcement practices. These understandings of appropriate practices were also apparent in the degree of informed consent needed in situations of sentinel surveillance of stored samples from STD clinics (Paterson, 1996: 37-41). Such stories of conflicts have continued within a general health ethics framework (Auckland Womans Health Council (2004), as a problem of collective consequences of collective surveillance, and as an unasked question about the appropriateness of protocols over the testing of used syringes. Sociological concerns over researchers claiming: "a right to deceive and manipulate people for research purposes" (Mann, 1985: 106) are thereby focused on IDU collectives, as well as on individual IDU. The offering of consent through representatives, without public protocols, suggests that there have been difficulties due to differences in the positioning of IDU and NEP personnel, as well as various types of health researcher.

Nancy Stoller's brief account (1998) of an illicit North American exchange, which came to be supported, co-ordinated, and normalised by local government agencies, offers an informative story from well after the formative and mid-period of the New Zealand NEP. Stoller's account has not been cited in any local reports or analyses of the NEP. In general, the different patterns of IDU practices, especially of 'street scenes' that have been unknown in New Zealand, have reduced the utility of North American ethnographies for this research. However, Stoller's analysis of organisational forms is sufficiently abstract, consolidated and generalised to translate across this gap. Stoller draws out themes of empowerment and improvisation through self-organisation by locating the exchange's founding with a group of pagan anarchists who participated in a network of marginalised peers. These founders deliberately resisted forming hierarchies and did not rely on

117. See Green, Goldberg, Frischer, Cameron, Taylor, & Grueret (1995).

118. This critique would also apply, though to a lesser degree, to my own work. However, I have twisted this problem into a form of productivity by identifying, scrutinising, and analysing the way it works in practice.

professional expertise. Stoller then describes a shift in this North American needle exchange towards bureaucratic institutionalisation, due in part to funding dependencies which co-evolved with the scale of the organisation's operations. The peer anarchist element in this story was similar to the founding of CIVDURG in Christchurch in 1988. Stoller highlights how differences between the management and volunteers became more significant due to shifts in the structures of funding and the types of opposition. This process told me about the importance of representation in situations where accounts and policies were being generated, or defended.

However, for my purposes Stoller does not adequately account for how the peers became repositioned or excluded in such developments. She describes how certain peers opposed the changes from self-management towards a hierarchy and left, while others stayed, and some indicated agreement with the changes, yet the reasons are only summarised from an external surmise and the sequences are only hinted at. Some peers worked so long that they effectively had an occupation, but Stoller does not develop this aspect in any depth. Nor was that exchange positioned in relation to a state-wide network of peers, meetings, and channels of information. These questions sensitised my search for documents and details to maximise the scope and relevance of following the objects, sources and mechanisms through which the NEP developments are usefully described.

A story of harm reduction, first as pushing out conventional prohibitionist policies of harm prevention in a particular area of syringe exchange, then as becoming partly subsumed into a policy of harm minimisation, runs through the NEP history. Harm reduction underlies the NEP in concept, but in actuality the NEP has defined and described how harm reduction acted and appeared in New Zealand. Some illustrative definitions were found in publications. For instance, the Royal New Zealand College of General Practitioners (RNZCGP) described harm reduction practices as accepting drug use as a fact while focusing on reducing harm for as long as drug use continues.¹¹⁹ Harm reduction in this story emphasises a range of individual goals, and reliance on evidenced research. The unique combination of factors in an individual's drug using environment are not reduced into a single universal systemic category, especially a category of ideological morality.¹²⁰

Harm reduction and harm minimising logics were used to alter how the NEP was labelled and perceived. This is a confusing area because the term 'harm minimisation' has frequently been found in close proximity to the everyday usage of 'reducing harm'. For instance, the Occupational Safety

119. This definition is offered by Riley (1999, as cited in The Royal New Zealand College of General Practitioners, 2005): "The essence of harm reduction is embodied in the following statement: "If a person is not willing to give up his or her drug use, we should assist them in reducing harm to himself or herself and other"" (Royal New Zealand College of General Practitioners, 2005).

120. For instance, Moore's (2004) actor-network analysis describes how the reconfiguration of particular activities of named substances, such as heroin, into a general category of 'drugs', altered the legal and health consequences for heroin users and treatment specialists. A dogmatic policy of eliminating all illicit drugs actually excluded the capability to provide evidence-based treatment services for users of a particular drug in particular circumstances.

and Health (OSH) definition of 'harm minimisation' included a reference to the primary goal being: "a net reduction in drug-related harm rather than becoming drug-free overnight" (Occupational Safety and Health, 2005).

After 1997, the New Zealand National Drug Policy of 'harm minimisation' absorbed and positioned the NEP's 'harm reduction' alongside law enforcement programmes of 'supply reduction', and 'demand reduction' programmes based on education, drug treatment, and punitive sentencing. The requirements for evidence-based research to back up and improve drug policy accordingly dwindled.¹²¹ However, some differences between reducing and minimising practices are notable, for instance in the OSH (2005)¹²² definition. Whereas the RNZCGP definition of harm reduction referred to people 'unwilling to give up' their drug use, the OSH definition of harm minimisation referred to people who could not be 'expected to stop' their drug use. These definitions illustrate a clear difference in their framing of authority and agency. In the RNZCGP version of 'harm reduction', people were credited with the ability and right to make their own decisions, despite hazards which would require reduction. The OSH version of 'harm minimising' positioned people as lacking the control to make decisions which comply with social ideals. The OSH site, which represents health officialdom, did not mention 'harm reduction', whereas the RNZCGP site, which represents health professionalism, did not mention 'harm minimising'.

A further difference lay in duration. Harm reduction has been presented as continuing indefinitely if it so chances, in contrast to a harm minimisation that would eventually cease when drug using ideally stopped. On a spectrum between dependence and abstinence, reduction and minimising in these senses appear as neighbouring rather than opposing concepts. This encouraged policy actors to shift the boundary between these concepts, leading to changing rationales for programmes and contexts for later actors. Nonetheless, harm minimisation has not relied totally on abstinence. Neither of these approaches to harm has promoted a total disregard for hazards, while both promoted reliance on an empirical evidence base.

The terms 'harm reduction' and 'harm minimisation' name two differing policies. Yet the terms 'reduction' and 'minimising' frequently interchange in popular usage and policy descriptions, while sometimes establishing specific distinctions. Apart from the shifts in New Zealand policy and method, harm reduction appears in overseas accounts, but close attention to context is needed when evaluating such material.

Stimson et al. (1991: 230) identify three specific factors that facilitated needle exchange

121. I would argue because existing institutions and organisations, with a legacy of moral legitimations and configurations as private fiefdoms, exhibited 'bureaucratic capture' and could resist accountability.

122. Harm minimisation is: "an approach that aims to minimise the adverse health, social and economic consequences of drug use, without necessarily ending such use for people who cannot be expected to stop their drug using immediately" (Occupational Safety and Health, 2005).

developments in England. There had been a pre-existing debate on harm minimisation, a wide range of potential institutional sites, and a social policy framework of central policy initiatives that emphasised local autonomy in implementation (Stimson et al., 1991: 230). The latter factor seems particularly significant in the New Zealand context. Rhodes & Hartnoll present a concept of outreach as providing “an interface between community and professional-based services” (1991: 243) which is both necessary and precarious because of conflicts at ideological and pragmatic levels. Rhodes & Hartnoll draw attention to the difficulties and need for systematic monitoring and evaluation of outreach services (1991: 243-245).

Davenport-Hines (2004) has identified the influence on UK policy of a small group of abstinence-fixated, mental health specialists. This segment of psychologists and psychiatrists 'captured' drug policy and resisted harm reduction programmes, following similar professional developments in North America, which were linked to political agendas that collaborated to support the 'war on drug-users' (2004: 369-374). Davenport-Hines points out that "... the prevalence of HIV among drug users was crucial to the British strategy of presenting the virus as a threat to the general population rather than as a by-product of homosexuality" (2004: 377). The crucial UK Committee that first presented medical evidence and judgement in support of harm reduction measures, such as needle exchanges, were predominantly "haematologists and virologists rather than consultant psychologists from the drug dependence clinics" (Davenport-Hines, 2004: 380). North American influences towards abstinence approaches also impacted on drug treatment concepts in New Zealand, yet not to the extent that Davenport-Hines describes in the UK. As discussed in Chapter 4, gay community organisers allied with health sector officials to more effectively reduce the decision-making power of health specialist groups in New Zealand (Smith, 1990: 2). Furthermore, GPs and pharmacists, who constituted a major segment of the primary health sector interface with the public, have been receptive to harm reduction concepts and have generally promoted the agency of health consumers, provided their own agency was not diminished in consequence.¹²³

Hulse (1997), has analysed community-oriented, Australian HIV/AIDS policy in relation to HCV policy. In his story, the crucial input of community organisations to national policy was strongly opposed by medical professionals and was later “unacknowledged by senior health bureaucrats and politicians” (1997: 171). Because the credit for a successful HIV outcome was attributed to a political and policy elite, IDU harm reduction and outreach organisations in following years had

123. The record of venereologists has been far more variable. See Kampf (2007: 9-12, 118-123, 130-133, 138, 142, 152-153, 156-163, 168, 176, 208.) - Kampf focuses on heterosexual practices, perhaps following the medical discourse of the period studied. However fleeting references to homosexual aspects began to appear in archival records from the late 1960s. See Kampf (2007: 175, 179-180). The first Venereology Conference in New Zealand was held in 1964. The New Zealand Society of Venereology was only established in 1978, barely preceding the advent of AIDS. Given the policing of womens' sexual practices by venereology practitioners and Department officials, together with strong moral conservative assumptions that impacted adversely on womens' sexual health, one can imagine that male homosexuals would have exerted great efforts to evade surveillance and control by the profession of venereology.

less credibility. It became more difficult to use their knowledge of grassroots practices to shape a national HCV strategy. Instead, policy became captured by established ‘mainstream’¹²⁴ sources (174-175).

Dr. Neal Blewett (1997), a gay medical professional who had been the Federal Minister of Health during the mid-1980s, responded to Hulse by claiming that there had never been an ‘effective’ IDU community that could provide policy advice ‘acceptable’ at a national level. Blewett presents a story of a desire by government to empower gay communities, but also utilising a counter-theme of IDU being inherently limited by their criminalisation to a street level type and degree of service delivery (177-178).

Bill Bowtell, who had been a senior advisor to Dr. Blewett after 1983 (Bowtell, 1997: 180), commented that community participation broke the monopoly of funding and advice decisions by medical and official elites, but these later made successful efforts to reassert their primacy. However, in New Zealand, similar story ingredients combined differently with different timings and emphases in expression. The initial policy input from IDU was high and preceded equivalent Australian developments. IDU peer input into NEP policy was then effectively excluded from 1990 to 1995, before regaining access and credibility through the infrastructural centralising of peer-professional service delivery organisations.

An early Dunedin study (Matthews & Leland, 1990) on public and IDU attitudes towards the innovation of the NEP, cited comments by Des Jarlais, a noted international researcher into harm reduction programmes. Des Jarlais had studied the earliest needle exchange programme in 1984 in Amsterdam. He characterised such programmes as subject to short-term ‘selection pressures’ which required the programmes to adapt to the needs of the IV drug users participating in the scheme as well as to the demands of those who funded the programme. He gave examples of UK schemes that were closed due to their inability to adapt to these sometimes conflicting requirements. He emphasised that the programmes were not static entities, but instead evolved to meet the conflicting needs of IDU, the needs of funding agencies, and the attitudes of local communities, according to Matthews & Leland (1990: 2-3). The Dunedin Intravenous Organisation (DIVO) began operating during the course of the survey, and this study was found in DIVO’s archive, suggesting that Des Jarlais’ generally theorised sense of ‘interactions of conflict’ was known in New Zealand. My concept of NEP hybridity fits well with the general concept of Des Jarlais (Des Jarlais & Friedman, 1991), and with concepts promoted by Nimmo in an internal, managerial analysis of the peer group operational role in his paper ‘*between a rock and a hard place*’ (Nimmo, 1995a).

Several partial accounts of the background and problems of the NEP have appeared during its

124. By ‘mainstream’ I refer to a cultural identity, rather than any group that can be empirically defined from the outside. Mainstream people are those who consider themselves to be the normal and rightful majority, whose opinions and directives should be obeyed in a democratic society.

development. Nonetheless, though wide-ranging and relevant, none fully address the questions that shape this thesis.¹²⁵ The first account laid out a prospective Management Plan for the NEP (Baker, 1987a, 1987b, 1987c). This was followed by quantitative reviews that included useful background and issues sections (Walker, Brady, & Baker, 1994; Lungely and Baker, 1990; Lungely, 1988). The other accounts were descriptive, or legitimations of proposals, the fullest being a report on management issues (Fitzgerald, 1995). Some accounts were insider positioned,¹²⁶ more-or-less oriented to Ministry of Health, or IDU peer, or NEP goals. For instance Auerbach's (1994d) review was not intended to be analytical, but rather to list stakeholder concerns. External reviews (Aitken, 2002; Walzl, 1994; Robinson, 1990) have included more qualitative analysis. However, external reviews are assumed to have followed and complied with the goals and environmental understandings of the NEP's funding and regulatory bodies. Only the accounts of Kemp (2004, 1996), Aitken (2002) and Lungely (1988) have been published.

These accounts have illustrated not only the development of the NEP as such, but also the changing policy environments of the writers. They describe problems of stability, funding, evaluation, co-ordination and performance. They tell stories about NEP peer-professionalism, yet in so doing, tell a counter-story of collaboration between the official, managerial and political aspects of the environment of the NEP. These accounts illustrate how people live socially through using stories as shaping, stabilising and sustaining technologies of interactional networking (Somers, 1994: 614). Social story-scapes seem as pervasive as land-scapes, object-scapes, techno-scapes and body-scapes (Turner 2001: 475-478, 499-502). This conception allows actual storied life to partially occupy accounts, such as the reviews explored here. This conception offers a way of understanding how stories can be active in the present moments of reading, re-visioning, and translating (Rich, 1990: 483-4).

2 Stories of communities and professionalising

The NEP, along with needle exchanges in general, developed partly alongside and partly within global HIV/AIDS policy frameworks. Many international comparisons of policy responses to HIV have resulted.¹²⁷ Berridge, for instance, describes phases of policy-making that have been linked to

125. I have been particularly interested in these reviews because they were constructed as 'wholes' with a narrative and analytical intent. However, an analytical comparison has been precluded by space considerations.

126. See Kemp (1990, 1993, 1996, 2003, 2004), McNicholas, Garret & Baker (1996), Auerbach (1994d), and Nimmo (1994a, 1995a, 1995b).

127. I have considered accounts of developmental phases by Berridge (1996, 1995, 1993), Patton (1990), Altman (1994), Stoller (1998: 139-147) and Hulse (1997). Other influential accounts include Aggleton, Weeks & Taylor-Laybourne (1993), Fox et al. (1989), Kramer (1989), Whitehead (1989) and Carr (1989). However, an alternative concept of sequences of public and policy 'states', ranging from urgency to normalisation, or complacency, is also found in Berridge (1996) and Street (1993). For phases of normalisation see Steffen (2000), Rosenbrock et al. (1995), van den Boom (1998), Day & Klein (1989), Porter & Porter (1988) and Downs (1972). Writing in a New Zealand context includes Parkinson & Hughes (1987), Lindberg & McMorland (1996), Davis & Lichtenstein (1996a,b) and Plumridge & Chetwynd (1994). For sequential stages of consensus construction see Crofts et al. (1994). These

phases of control of service delivery. These phases included the evasion by health professionals of accountability for HIV/AIDS, along with innovative community organisation and service provision, followed by re-occupation of such service provision environments by health professionals and health bureaucrats. Most analyses of general responses to HIV/AIDS identify three or four phases of policy change, where community control is accepted and empowered during an initial state of crisis, before being limited, reduced, and assimilated in successive later phases. At the same time, the engagement of community organisations in policy and service delivery often increases, yet in either more politicised or more institutionalised ways (Altman, 1994). New Zealand's institutionalised policy responses have been critiqued, along with those of other countries, as 'selling out' by Altman.¹²⁸

Patton (1990) has described a pattern of autonomous, distributed, grass-roots community organisation, initially conflicting with centralised government and health professionals, yet becoming more centralised during a later phase. A single institution, possibly constituted from competing elements united by common goals of funding and status, exhibits shape and coherency through the structuring logics, and professionalisation of NEP services. In Patton's account, these professional accountabilities are multiple, with related sets applying to publics, special groups, and to the maintenance of territorial boundaries.

Stories that link legal rights to moral codes and to personal health feature strongly in sociology. For instance: "the 'good' citizen in the modern world is the 'healthy' citizen" according to Petersen & Lupton (1996, in Bashford & Nugent, 2001: 112).¹²⁹ Moral narratives (Rousseau, 1981), which were challenged after the Nuremberg Trials by ethical constraints on scientific knowledge acquisition, have troubled the methods of health professionals and social scientists. Yet IDU are equally troubled when persuaded or induced to be 'good' by being 'healthy' while injecting illicit drugs. I was sensitised to such stories where they appeared in accounts of NEP policy arguments and of monitoring NEP clients, due to my direct experience of being a moral 'associate member' of an excluded social group that nonetheless considered illicit drug use to be completely normal. My awareness of personal vulnerability extended to a wider network of collective vulnerability. Here I was informed by the AIDS stories about communities (Altman), intersecting collective vulnerabilities (Stoller), on the policies of AIDS testing, and of political exclusions from 'the public' for health reasons as well as legal sanctions and moral stigma (Baldwin, 2005; Brown,

different concepts of phases and sequences may be treated as complementary perspectives.

128. "Community organizations need to walk a fine line between seeking to influence the agenda and performance of governments and becoming subsumed into the interests of the state. In some countries - I have heard this criticism about both New Zealand and Denmark ... the constituencies of successful AIDS organizations see them as having 'sold out' to the demands of the bureaucratic state" (Altman, 1994: 162).

129. Petersen & Lupton (1996, in Bashford & Nugent, 2001: 112)) discuss the Aborigine patient's 'careless and irresponsible habits' that 'render it impossible to keep him under observation, or to submit himself to a course of treatment unless he is under restraint'"(112). Bashford & Nugent relate the 'compulsory isolation' of Aboriginal people to their perceived 'incapacity for modern citizenship" (2001: 108).

1999, 1997). I followed the attention these authors¹³⁰ paid to how individuals and groups have been excluded from participating in ‘the public’ domain of citizenship. These authors drew attention to the significance of gains, however small or contested, of a public voice through methods particular to geographic and historical localities. In my account I emphasise moral narratives about drug use and drug prohibition in particular.

However, the unique historical and geographical features of New Zealand reduce the relevance of direct comparisons between the NEP and international needle exchanges. In consequence, I have assumed that a longitudinal comparison of NEP developments within New Zealand can be effective¹³¹ and can usefully precede international comparisons. Furthermore, shallow international comparisons hold dangers. For instance, comparisons with rapidly gathered Australian statistics can generate numerical differences, but of uncertain relevance and significance, whereas trans-Tasman evaluations that attribute too much value too quickly entail an assumption that differences between Australian and New Zealand environments ‘should’ reduce.¹³² The consequences and meaning of international comparisons require greater specification of what case parameters are being selected, or generated, or compared, and why. Given my even-handed scepticism towards expert testimony and documentary accounts, and my commitment to accessing all the available records, a trans-Tasman study in such detail would have been unachievable within my research constraints. Instead I have explored the near context of the NEP, following closely connected policies and programmes in New Zealand.

Lindberg & McMorland (1996: 103-115), and Davis & Lichtenstein (1996a: 3-7, 1996b: 226-227) have applied the useful, conventional concept of phases to the New Zealand AIDS Foundation (NZAF) history. These phases do not specifically analyse any pattern of accountabilities between the NZAF and state agencies, yet it seems implied that professional organisations would not directly challenge their government (Lindberg & McMorland, 1996: 104). Nonetheless, Lindberg does not emphasise how the AIDS Service Network, which was the precursor to the New Zealand AIDS Foundation, competed for jurisdiction with conventional medical professions over issues such as control of biomedical testing policy, and provision of prevention services.¹³³

130. Baldwin (2005) and also Brown (1999, 1997) analyse wider relationships between diseases and democracy in terms of connections and differences between private and public practices. Baldwin utilises a model of complex and unpredictable tradeoffs between the regulation of public health benefits and civil liberties. Both analysts approach such relationships through case studies in AIDS policy. Brown restricts himself to a geographical study of North American and New Zealand localities. Baldwin provides a wider comparison of AIDS policy differences across industrialised societies. This builds on his earlier work on relationships between epidemics and state policy in Europe (Baldwin, 1999).

131. Such comparisons might become increasingly valid if New Zealand drug use patterns, methods of harm reduction, and standards of record keeping, approached Australian norms, or vice-versa. This would make regular comparison easier but would also lead to pressure to copy Australian monitoring and evaluation methodologies. Since local methodologies, despite faults, are developed for local conditions, their replacement poses risks.

132. Such a political project with ideological underpinnings is not promoted, either overtly or covertly, in my analysis.

133. Warren Lindberg was the Director of the NZAF over most of the period I deal with. Lindberg’s presentation illustrates how the NZAF had come to control a health jurisdiction, rather than opposing or resisting medical domination. This control involved acting similarly to other health managers, who find it expedient to follow a

Other New Zealand focused accounts¹³⁴ of marginalised communities¹³⁵ have been written by Phil Parkinson (Parkinson & Hughes, 1987). Parkinson has been admirably direct in his descriptions of historical and continuing conflicts of interest between treatment professionals and the gay community (National Council on AIDS, 1988b: 1-2). Parkinson & Hughes (1987) and Lindberg & McMorland (1996) have summarised how HIV support and education funding was primarily community driven, with minimal government contribution, until quite late in the development of co-ordinated responses. Michael Brown (1999) has analysed HIV/AIDS programmes and organisations in Christchurch in terms of 'regime theory'. Brown notes how arrangements between public and private spheres have led to HIV/AIDS governance practices being characterised by flexibility, yet also by difficulties in maintaining governance coalitions.

I initially studied Altman's (1994: 6, 7, 162, 167) analysis of the relationship between community organising and state programme development. Altman argued that: "Wherever it is possible, there will be grassroots responses to the demands of the epidemic, and no government or international agency program can be effective if it does not cooperate with, and support, such responses" (1994: 166). He generalised this analysis across different societies, and it clearly applies to the New Zealand NEP.

Altman focused on the significance of linkages between community organisations and state agencies. He raised awareness of problems inherent to expanding governance capabilities through methods which could lead to 'detachment' from community foundations and accesses. He also problematised his own use of the term 'community', showing how it could be highly politically laden and differently understood (1994: 7-8). But Altman seemed to have no alternative given that his analysis was not grounded in any particular society and therefore needed a general unspecified term that readily crossed different societies.

Altman has not offered any close, in-depth case study that explains capabilities in terms of sustaining, shaping, and stabilising effects (Campbell, 2004: 62-65; Tilly, 1997b: 6-9, 44-45) by exploring local developmental conditions. Yet Altman's analysis continues to portray the necessity

medical collegiate code of never denigrating fellow health professionals in public conflicts over professional territory (without extreme provocation). Constant conflict over turf is disguised by professional needs to maintain collegiality, to work in collaboration with different health professions and managers, and to maintain public trust in the medical profession being selfless and expert.

134. Various analysts have discussed the control of accounts, stories and cultural constructions of HIV/AIDS. Such work informs the generation, understandings, and evaluations of accounts in a variety of ways, for a variety of individual and institutional causes. See Treichler (1999), Epstein (1996) and Waldby (1996). Gilman (1988), emphasised how HIV/AIDS co-existed with and was shaped by responses to older STDs. Lichtenstein (1996), followed Gilman in a New Zealand context, while also offering impressive local contextual detail of AIDS service organisations and their connections to state agencies.
135. For New Zealand Prostitutes Collective and New Zealand sexwork accounts see Perez-y-Perez (2004), Plumridge & Abel (2001), Plumridge, Chetwynd, Reed, & Gifford. (1997), Plumridge, Reed, & Gifford (1997), Eden (1997), Chetwynd (1996) and Lichtenstein (1996: 300-314). The New Zealand Prostitutes Collective provided a discreet needle exchange service within the NEP by the mid-1990s. Jang (2003) has written a short unpublished paper on the social environment of the Hepatitis C Resource Centre, which developed out of the Christchurch peer exchange.

and consequent institutionalising of grass-roots community organising:

The development of AIDS organizations often plays a significant role in building a sense of community in stigmatized groups ... [however] any idea of 'community based' must involve some sense that the organization represents the community in question, and how this is done is one of the major theoretical problems facing almost all AIDS CBOs. (Altman 1994: 7)

Altman emphasises that centralisation and other forms of distancing from grass-roots community networks, does not characteristically emerge as pressure from below, but is instead pulled from above:

In only a few countries are there effective national networks embracing all - or even the bulk - of community-based AIDS organizations. Where these have been created, this is often ... at the instigation of central governments eager to establish one peak body with whom they can deal. (Altman, 1994: 101)

Lindberg & McMorland (1996) offer an account of a NZAF that became increasingly capable as it moved from grass-roots to corporate to professional identity. Despite greater social distances being involved in a shift from a 'flat' politics of gay community to a hierarchal connection between grass-roots and policy elites, this distancing was not followed by the development of continuing divisions, although some divisions did emerge. Kemp (2004) notes that the AIDS Task Force, then a division of the Department of Health, attempted to reduce the centralised, professional influence of the NZAF, and any similar organisation, by promoting independent local initiatives. Kemp infers that this was a significant aspect of the crucial decision to offer contracts to the initial IDU peer outreach groups on a regionally independent basis. Nimmo (1995a) warns of some criticisms from the 'gay community' of the NZAF becoming detached from its roots, yet proposes that needle exchange development should be modelled on the NZAF example of 'professionalising'.

Stoller (1998) continued and supported Altman's themes, with special emphasis on conflicts within community organisations. Stoller focused more closely on the situations of minorities and the marginalised in North America, looking more at how being poor, a woman, and black intersected with being gay. Altman and Stoller combined local case studies more symmetrically with wider, more generalisable theorising. Both authors generalise 'outward' to provide conceptual frameworks that continue to be relevant to modern industrialised western societies. They tend to focus on communities and health. Along with Treichler (1999), Altman and Stoller are often sensitive to the consequences and significance of professionalising expert knowledges. Yet they generally ignore the social construction of crime (Becker, 1973, 1964), for instance in how drug criminalisation in the U.S. through the 20th century was mutually entangled with the increasing influence of medical professionalism and with the medicalisation of substances and substance using motivations (Courtwright, 2001, 1997, 1982).

Analyses from the U.S., however, cannot explain phases in the development of the New Zealand NEP. These phases are best understood as parts of whole events, for instance within longer

duration dependencies and conflicts between state agencies and medical professionals, yet also embedded in local environments. Alternatively, the phases in the NEP development might be further broken down into analyses of the logics and expectations that participants experienced as en-scripted into social institutions and objects. Such logics and expectations would appear to inform the workability of the policy, regulations and implementation of the NEP as understood by participating actors at any moment. It seems necessary, accordingly, to select sites where such understandings of the NEP were being applied. I have paid attention to the grounded sites of everyday IDU life, and everyday peer-professional work, because policy makers can only propose, not dispose. Policy would not have happened as practice unless other people agreed to participate in approved actions and communications. Yet such information is very difficult to acquire directly from the everyday worlds of illicit and stigmatised people.

The NEP has been explained as a story of a characteristic consensus or enlightened response (Paterson, 1996), or as an account of an initial experiment that turned rapidly and successfully into an institution of 'partnership' between communities, professionals and state agencies.¹³⁶ The conventional NEP explanation of origins is an adaptation of this model, which seems based primarily on the NZAF's formative history.¹³⁷ Yet Plumridge and Chetwynd's (1994) analysis of New Zealand policy responses to HIV/AIDS concludes that popular accounts invoking a 'natural' or prior consensus that explains local developments in prevention and support, are inadequate. Plumridge and Chetwynd offer a more institutional account of 'manufactured consensus' (1994) which supports Kemp's description (2004) of Department of Health tactics of 'contrived spontaneity' and the UK accounts of 'manipulated emergence' (Harrison & Wood, 1999). A story emerges of a governance method of managing potential disorder and reassuring the public by enrolling representatives of marginalised communities in programmes that offer health services to their peers.¹³⁸

There is considerable evidence to support such stories, but such accounts do not adequately explain the particular situations observed in the development of the New Zealand NEP. Models of

136. See Davis & Lichtenstein (1996b), Plumridge & Chetwynd (1994), Crofts et al. (1994: 50). However Plumridge and Chetwynd support Berridge's analysis, in New Zealand contexts, by demonstrating negotiated conflicts through which consensus emerged. For Australian perspectives see Hulse (1997) and Blewett (1997). Crofts et al. (1994) discuss community involvement in policy responses and 'ad-hoc' partnership models. Hulse critiqued Australia's changing degree of inclusion of 'affected' communities in public health responses to HIV and HCV. Ex-Minister of Health, Neal Blewett (1997) quickly responded in defence of government policies. For discussion of partnership between marginalised community groups and state agencies in the context of womens' refuges in New Zealand see MacGibbon (2002: 20-22). Surtees (2003: 36-48) and Tully, Daellenbach & Guilliland (1998: 245-255), discuss partnership aspects of the professionalising of midwives in New Zealand. Women's refuges and midwifery are notable for being based on a peer principle, yet also requiring state agency funding, regulation, and shelter according to bureaucratic principles. Such hybrid 'partnership' situations seem similar to those of needle exchanges.

137. See Lindberg & McMorland (1996: 105), Parkinson & Hughes (1987).

138. The profession of venereology had popularised the concept of 'at risk' groups during the late 1960s, together with the concept of being 'peers' rather than enforcers of moral agendas. However, the actual practices maintained a professional divide between practitioners and community, with no Departmental support for community based sexual health education by actual peers. See Kampf (2007: 188, 190, 212). Venereologists were not prepared to directly challenge the stigma that linked venereal disease with illicit or deviant sexual practices.

consensus and partnerships in IDU worlds do offer approaches for researchers, despite structural ambiguities and some counter-evidence. Consensus and partnership goals have seemed prevalent within the New Zealand health sector policy community.¹³⁹ This partly explains a variation emerging in the form of the AIDS Service Network and the NZAF. Yet consensus and partnership in the NEP context have seemed more driven by contingencies, chance, and personal charisma in unique events that demonstrated path-dependent consequences (Lichtenstein, 1996: 405-411). Nor had my personal NEP experiences of governance through such enrolments appeared as smooth or reliable from the inside. More general stories of problems inherent to commercial and managerial models of health, seemed as well-evidenced and as likely to discretely appear in officially commissioned reviews of the NEP, as those of consensus and partnership.

Comparatively little ethnographic work has been done among New Zealand IDU (Kemp, 1996: 154). Of the available work,¹⁴⁰ most has been done through clients of needle exchanges, which might distort representativeness. However, information derived from law enforcement 'clients' and those in voluntary treatment seems likely to be far more distorted, as apparent in decades of denials by Corrections Department officials that injecting drug use took place in New Zealand prisons. Such deliberate misinformation by corrupt officials was only possible because IDU inmates could not afford to tell their stories against those who controlled their environments. In being convicted criminals, their public voice had been curtailed in access and status. IDU in treatment are also very different from those in everyday drug-using contexts. Information originating from undistorted IDU experiences is particularly useful because the use of actor network analysis requires treating criminal or otherwise marginalised perspectives in the same way as law enforcement perspectives. Actor-network methods alert the research to effects being co-produced from heterogeneous alliances. From this perspective, studies of syringe movements also study the movements and motivations of IDU .

Despite several overt gaps in policy and implementation documentation, the most direct absence of sources that has impinged on this research has been the erratic character of the documentary record of the NEP. The depth and range of understandings found in the documentation of the early history of the NEP seems generally poor. I explain this by pointing to the stigma of the IDU situation, combined with the secrecy characteristic of IDU, officials, and the keeping of histories. People who knew about the NEP were either working within it or employed by state agencies in related areas,

139. See Barnett, Malcolm, Wright, & Hendry (2004), Barnett & Barnett (2004), Gauld (2001a: 429-430) and Barnett & Barnett (1999).

140. Matthews & Leland (1990) surveyed public and consumer attitudes in Dunedin just as the local peer group began operating. Plumridge and Chetwynd (1999, 1998) sampled the 'moral worlds' found in the everyday life of IDU who share needles and syringes. Anonymous telephone surveys from the mid-1990s have produced data on illicit drug use. However, the accuracy in terms of injecting drug use is questionable, being counter-indicated by HCV incidence rates. As illicit drugs become normalised, telephone research technologies have become more feasible. Accordingly, they provide a measure of illicit drug normalisation when compared with more precise measures based on incidence rates of marker diseases such as HCV.

providing reasons to not enquire too deeply. Such contexts explain why peer-professional patterns I describe have not been specifically written about by the participants who experienced them.

Moreover, such absences seem in no way exceptional in the health sector.¹⁴¹

Over the same research period that I obtained archival material on the conflicts over the expert advice to the Minister, I drew on actor-network accounts of the scientific expertise featuring in medical professionalism. Professionalism was a story that some NEP actors cited and understood well (Nimmo, 1995a, b, c). Professionalisation has been associated with establishing collegiate linkages and public status for private practices through trust, whereas bureaucratisation has been linked to directing activities through regulation.¹⁴² Professions¹⁴³ may usefully be treated as institutions in themselves, and as constituents of governmentality systems.¹⁴⁴ This trail circled back into a structural model of conflicts between medical professional interests and IDU interests.

Andrew Abbott treated disciplines and professions similarly to careers, in being constituents in wider structural systems that develop historically, and in more extensive and chancy environments than an 'ideal type' instrument can explain. Abbott (2001, 1990) combines interactional analyses of professionalising processes with philosophical and methodological explorations of time and history.

Abbott tells a story (1999, 1992a, 1988, 1982) about historical changes in professional jurisdictions produced by boundary shifts in a system of inherent exclusions and conflicts. This story presents professional characteristics as traits associated with a configuration of conflict and control processes.¹⁴⁵ To Abbott's more precise story of 'profession' and 'professionalising', I add an everyday, generalised complement that refers to an excellent degree of quality and reliability in commercial transactions.

Abbott shows how some forms of professional domination work by comparing and contrasting potentially changeable professional boundaries with their provisional solidification through social

141. I have been intrigued by the number of medical and nursing textbooks that do not have a publishing date. It is as if the books are claiming to be timeless authorities, despite generally being one of many editions. In certain ways, health as practiced seems highly resistant to the idea of health as within history, and health best practices as never adequate by later standards.

142. Both methods offer guarantees of dependability and accountability, but different expectations, methods, and consequences. I consider managerialism to relate to corporate environments that can 'speak with a single voice', if needed, and are suited to working towards a single or narrowly constrained set of goals. Nonetheless, during the period studied various collegiate and official health systems were reconfigured in a corporatist form and mode during neo-liberal experiments in New Zealand's state sector governance. This has meant that the relationship between administrators, officials, and managers became less specified and more overlapping, at least in potential.

143. Patients, officials, politicians, and other professions all require health professional work to take place. For discussion on professions, semi-professions, deprofessionalisation, and clinical governance in conventional and new forms see Döhler (1989), Bucher (1988), Tordoir (1995), Reiter [undated], Abbott (1992a, 1988: 161), Freidson (2001, 1999, 1994, 1990, 1975, 1970), Evetts (2003), Le Bianic (2003), Elston (1991: 59), Larson (1977), Johnson (1995, 1972), Bucher & Strauss (1961), Hall (1949). The NEP developments did not seem semi-professional (Etzioni, 1969; Toren, 1972), post-professional (Burns, 2007) functional trait-oriented (Flexner, 1915; Greenwood, 1957; Wilensky, 1964; Pavalko, 1988) or power-holding (Johnson, 1995; Larson, 1977; Freidson, 1970), because the criminal aspect of injecting illicit drug ensured that qualified professionals were driven away, despite the health provision goals of the NEP. For theorisation of complex service organisations see Hasenfeld (1992), Gronbjerg (1992). For analysis of

expectations, laws, and conflicts.¹⁴⁶ Abbott's boundaries seem inherent aspects of communication and shared expectations, which become legally categorised and infrastructurally consolidated into 'professional territory'. Such territory may be conceived of as the shaped and reshaped zones of jurisdiction, where the actual connections and disconnections of professionalising practices in everyday work are delineated. Abbott conceives of multiple boundary conditions becoming joined into a new boundary in a process of assembling, consolidating, stabilising, and expanding of organisations and institutions. As I interpret this argument, the initial line of division with respect to professional boundaries does not necessarily remain, because Abbott acknowledges that social structures are in constant change (Abbott, 2001: 254, 257, 263, 266, 296).

According to Abbott, institutional boundaries, including the territorial rearrangements of professions over time, may precede the naming of the consequent entity. Abbott (2001: 261-279) suggests that instead of analysts finding prior entities in order to find the revealing boundary sites, analysts should look for the boundary conditions. Such conditions may even possibly come before the material infrastructural changes, such as the address, the office, the university, and the employee wage system that become assembled to form the supportive organising of named entities. However, this suggestion draws attention to the various types of activity of material objects that could constitute such conditions of assemblage.

I have used Abbott to inform my approach to the intersections where illicit activities meet professional boundaries. Abbott offers a story of solid boundaries of institutional expectations which are difficult to clearly describe in purely organisational terms, but become clearer as a history. Abbott's story indicates how consensus and partnerships in the NEP might be constructed as history. Moreover, Boston et al. (1996) focused on the need for trust¹⁴⁷ since the erosion of professionalism could compromise the management and design of state sector policy. I considered that IDU deviance, alongside forms of general health sector consensus and professional territorial conflicts over jurisdictions,¹⁴⁸ seemed more durable and explanatory as co-factors than many of the

discretionary work practices outside of major state sheltered professions, in European contexts, see Le Bianic (2003), Evetts (2003), Tordoir (1995), Elston (1991: 59), Döhler (1989), Habenstein (1970), Reiter ([undated]). Tordoir (1995) describes European concepts of professionalism as less formal, less centred on state protection of territory and institutional reproduction, involving more employment by state agencies, and being more defined by the degree of discretionary judgement in everyday work. I consider the NEP has more in common with European than UK or US models of professionalism.

144. I considered shifting my case away from the actual NEP, towards the theoretical frameworks of the sociology of professions, but feared my approach would be more obscuratory than exploratory. I have not pursued such wider frameworks beyond the context needed to explain the conflicts with IDU and health officials/managers that became incorporated into the NEP. Governmentality perspectives might have been used to explore the needle exchange area, especially aspects of surveillance, and the 'arrangements of life itself', as in the institutionalisation of IDU and peer role types. However, I decided against this approach. I consider it would entail more theoretical baggage, and is less attuned to objects and interactional networks, than historical, interactionist and ANT approaches. However, some governmentality approaches overlap with actor-network approaches (Valentine, 2007: 500). See, for instance Rose & Novas (2003), Haggerty (2001), Rose (2001). I think it useful for actor-network and historical/philosophical methods to be applied to the crucial surveillance aspects and questions of governmentality.

145. See Abbott's study of the development of the psychiatric profession in the United States (1982). Abbott puts aside Weberian, ideal type of comparative understandings of professions and instead develops an understanding based on a single case study of the organisation of an occupation (Abbott, 1982: 4). Abbott's (1988) trait definition of

policy and organisational phases found in conventional accounts of the NEP and general HIV/AIDS policy.

My account of the NEP has featured a ‘peer-professional’ concept and practice that links analyses of communities and institutions to illicit objects and occupations. Peer-professionalising does not refer to professionals who become secret IDU, nor to ex-users who qualify as counselling professionals. Instead I refer to the public face of illicit drug use, combined with professional standards of work and professional aspirations for autonomy and public trust. Nor is professional training or qualification required, provided that professional types of goals, logics, and practices are pursued. The term attempts to encapsulate the adaptive character of the peer capabilities for making decisions within a deliberate and necessary, yet also uneasy, entangled and ambiguous, hybrid linking of criminal drug worlds to professional health worlds. I have not found any directly comparable concept in the academic literature.

Peer-professionalism can be observed in the NEP’s ‘blood awareness’ educational campaign.¹⁴⁹ This attempts to motivate IDU to be aware of a zone of potentially contagious surfaces around any act of injection. The goal is not only to reduce harm by improving environmental safety and encouraging IDU to adopt a calculated, precautionary stance. It is also to improve the quality of health promotion information, particularly its accuracy and receptivity to on-going research findings. The ‘best practice’ of NEP peers in this instance is to promote ideal harm reduction standards and find pragmatic ways of approaching these, rather than using the difficulties to legitimise the acceptance of average or lower standards.¹⁵⁰ More generally, I have asked how professionals and peers evaluated each other, and were evaluated by others due to their collaboration in the NEP.¹⁵¹ I also considered how peers and professionals enhanced their capabilities by supporting or restraining each other in public.

The concept of hybrid ¹⁵² peer-professionalism emerged slowly.¹⁵³ The concept consolidated from

professionalisation in North America involved three core, and four significant processes of professionalism. The core processes were: “the change from individual to group practice, the cultivation of rationalized or scientific knowledge, and the creation and maintenance of particular clienteles” (1982: 1). The significant processes were: “the play of individual incentives, the goal of professional autonomy, the implications of professional knowledge, and the requirements of social control” (1982: 1). Abbott cited eight general characteristics of professionalism, three being fundamental, consisting of expertise (knowledgeable skills), qualification (special training in those skills), and certification (control over services, licensing, monopoly, and ethics). Abbott appended less critical but still significant aspects, such as fixed remuneration, altruism, strong associations in a professional body, vocational subculture, and a foundation of client trust. Abbott cites Millerson (1964), and Hughes (1958) for the range of conventional understandings of professionalism.

146. Burns (2007: 82) disagrees.

147. Boston et al. (1996) write from the outside, and top-down, delicately outlining problems and robustly celebrating the state sector changes after 1984. Their critique is, accordingly, more compelling than a critical perspective.

148. There have been long-term conflicts between health professions and state officials over control of health budgets (Immergut’s, 1992). Reviews of the prevalence and incidence of HIV that originated from clinics, both overseas and from New Zealand, seemed important in providing a ‘sheltering umbrella’ for the IDU peers who were employed and normalised in the NEP. Such reviews provided evidence that syringe supply did not cause increases in other health problems related to injecting practices. However, the health sector had been reduced in status by social movements for de-medicalisation and by public conflicts over professional dominance. For instance, a Government report

an interplay between evidence, critical analysis, and participant responses to initial memos and presentations. In the process I borrowed structural elements and rationales from the previous stories, from my personal experiences in the NEP, from the shunning of peer outreach by the addiction treatment industry, from the threat of a peer strike in 2001, and by considering how a small number of individual NEP 'policy entrepreneurs' both differed from their peers, yet were also more understandable when peer norms and expectations were considered. The peer concept helped connect this train of logic to the issue of peer-to-peer counselling, and to a way of explaining continuous change within stable boundaries. I evaluated the degree to which all the NEP peers were actively using identifiably peer-professional types of concepts. Peer administrators including Burnett, Wright, Kemp, Nimmo, and Henderson expressed partial aspects of such ideas. As I interpret their words, they were hunting for a vocabulary and grammar to carry their meaning more succinctly and reliably. This suggested that their NEP environment and organisation was better described by using a formalisation of such terms and articulations. An actor-network sensitivity ensured that I did not simply formalise a typology out of these realisations, but instead encouraged the emergence of a concept of dynamic instability of an assemblage of heterogeneous elements. These held themselves in provisional alignment by means of circulating object, expected accountabilities, expertise of experience, professional landscapes, commercial logics, harm reduction ethos, and personal work.

I followed hybrid connections between peer-professional individuals and organisations, in historically contingent peer-professional environments, through their occurrences, sequences, structures, and significance as ongoing events. This approach has overlapped with new institutional approaches. These ask how organisations become institutionally 'locked in' to the shapes of founding environments and embedments; how accidents of organisational birth become presented as essential elements of stability in accounts; how control of institutional reproduction leads to professional types of attempts to assimilate the territorial jurisdictions of other occupations; and

(Cartwright, 1988) into the 'unfortunate experiment' conducted by Dr. Green at National Woman's Hospital remained influential in 2007. The report told a story of a need for patients and others to distrust the potential abuse of medical expertise, authority, and collegiality. Specialised, collegial expertise was presented as a significant reason for medical professionals being at times effectively unaccountable to patients, public, politicians, and officials charged with rationing health services within set budgets.

149. See Appendices 4 & 5 on Blood Awareness and other safety campaigns.

150. See Appendices 4 & 5 on Blood Awareness and other safety campaigns.

151. See Fear & Barnett (2003) for a discussion of recent New Zealand developments in collaborative health work.

152. Yet the general concept of hybrid organisations and institutions have not been common as tools of analysis, especially policy analysis. I suspect this is because hybrid assemblages seem to undercut, or more accurately, overflow beyond, the simplifying aspects of typologic approaches. Instead of locating a case in relation to ideal types in a static approach, hybrid activity appeals to uncertainty due to emphasising the instability and constructed non-reality of types and type-based comparisons. Nevertheless, hybrid examples have not seemed contentious when limited to particular phenomena and cases, rather than presented, as in some actor-network approaches such as Latour's, as a pervasive aspect of reality. D'Aunno (1992: 352-354) uses a hybrid model to characterise and evaluate how the Alcoholics Anonymous 'addiction as a single disease' self-help models have mixed in North America with mental health 'psychosocial adjustment to environment' professional models. Kirk & Kutichins (1992) do not refer to hybridity yet offer a description of rather hybrid paradox and uncertainty in mental health organisations. Tuunainen's (2005) *Contesting a Hybrid Firm at a Traditional University* offers a descriptive

how, in general, an ecological approach might be taken to the way the claims of some occupational groups are more readily accepted, while those of others are rejected or questioned (Powell, 1991, 1987). Some institutionalists, such as Büthe (2002: 487), accept a mix of historical narrative analysis and model analysis, yet reject attempts to form structural analyses of event sequences from the development of network boundary analyses. I differ in finding such approaches useful¹⁵⁴

I have found no direct treatment of a concept of hybrid peer-professionalism between crime and health in social science literature.¹⁵⁵ There are stories about the legal hazards faced by outreach workers and researchers in criminal situations, such as where injecting drug networks interact with HIV/AIDS programmes. The discussion on legal hazards approaches my focus on productive conflicts between professional types of goals and accountabilities and those of IDU peers.¹⁵⁶ There are stories of communities unifying or allying in consensus, of communities and officials creating a partnership model¹⁵⁷ of working together on mutually benefiting policy or organisational phases, of pragmatic necessities of the moment, of conflict, of betrayal, of loyalty, and of contingencies. Syringes, in their patterns of kinaesthetic movements, told stories, similar to how a river tells stories of its slower-flowing environment. I particularly value the stories which offer precise details of how developments proceeded (Berridge & Strong, 1991). These various types of accounts have influenced my research perspectives. Single case studies inherently configure the intersection of multiple disciplinary fields. In the NEP case, fields such as geography, history, phenomenology, systems philosophy, holistic health care, biomedicine, anthropology, and epidemiology have been drawn on. This review is intended as a brief guide to the research relevance of such storied accountings. It is offered not as an exhaustive survey of such fields and worlds, nor as a detailed diary of changing itineraries along a research trail, but instead of the relationship of each to the other.

analysis of conflict between academic and commercial hybridity where conventional concepts of hybridity are either locationally separated forms of “close collaboration networks between different actors” (2005: 175) or where staff have simultaneous academic and entrepreneurial accountabilities such that “the dividing lines between academic research and industrial development seems to vanish altogether” (2005: 175-176). Hybridity is initially presented as coalescing clearly distinct areas yet Tuunainen proceeds to problematise these understandings in a boundary analysis similar to my treatment of the hybridity of the Needle Exchange Programme. See also Guston (2001) on boundary organisations. Criminologists have utilised a general model of an uneasy hybridity between public and private forms of security provision, although such usage has been critiqued as rigidly structural and non-historical (Johnston, 1992), (Sheptycki, 1999: 223), Stenning & Shearing (1980), and Walker (1978).

153. It did not appear in a presentation eight months after beginning the research, but did in a presentation 12 months later.

154. See Abell (1993), de Swaan (1988), Appendix 9, particularly 9.6.

155. General concepts of niche formation have been articulated in ecological evolutionary literature by Odling-Smee, Laland & Feldman (2003). These are concepts that link individuals with groups as constituents of whole systems that develop over time in partially controlled material and activity environments. Such environments are inhabited by individuals that may be agents in how, through environmental modification, they can alter their constraints and opportunities in path-dependent ways. This work seems usefully applied to human activities, such as the production, transport and use of objects, and as a heuristic for explaining possibilities of semi-stable developments in the intersection of health and crime activities (Manning & Godfray, 2004; Laland & Odling-Smee, 2003).

Section 2

Assembling a Social History

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156. (See, for instance, Fitzgerald & Hamilton (1997), Fitzgerald (1996), Broadhead & Heckathorn, (1994), Friedman (1993), Griffiths, Gossop, Powis & Strang (1993), Power & Harkinson (1993), Sterk-Elifsen (1993), Grund, Blanken, Adriaans, Kaplan, Barendregt & Meeuwsen (1992)).
157. See Fitzgerald (1995: 14), National Council on AIDS (1990a: 80), NEP (2001: 3).

Professional shapings: Specialists, pharmacists, and officials

The actual rearranging of life and death is producing cross-talks that are forcing us to redescribe our philosophical inquiries, particularly to let go of extremely durable recurrent binaries. ...there is no way of doing ethical action outside of actual engagement, ... so that domains of practice make claims on each other, which at times results in partial translation and stuttering communication. ...That is not a barrier, it is the condition of signification.

(*The Birth of the Kennel: Cyborgs, Dogs and Companion Species*. Donna Haraway, 2000c: np, with stutters)

1 Connecting sex and drugs: does it matter which came first?

In this chapter I begin the substantive steps in my argument that the NEP capabilities have been partly unique, partly path-dependent, and characterised by a peer-professional principle. I have described how my approach of linking object and institutional mechanisms to event cycles and to the shapes of actor understandings, suits the exploration of single cases such as the NEP. An international review of the efficacy of needle exchanges noted that: "... both intentional and unintentional barriers ... are often specific to local settings, [yet] there are often common structural, legal, and ideological barriers that can be identified ..." (Strathdee & Vlahov, 2001). I treat local settings as actively connected to such structural, legal, and ideological barriers. I suggest that widespread professional practices connected to first gay, then IDU 'inside knowledge', despite distinctly different community logics of motivation. In this chapter I begin to apply these methods to the documents and stories that record the NEP case.

How do I know this is the beginning? Specifying beginnings and endings is a long-standing and contentious issue in historical case analysis. I initially thought the NEP began shortly before its legislative framework was enacted in December 1987. I imagined that my analysis would follow the implementing and adjustment of these laws and regulations. Yet the more I told that story, the more it was queried and resisted by the details in earlier documents. I responded by following these questions and references.

I found that the NEP story did not start with the labelling of Gay-Related Immunodeficiency Disease (GRID), nor with the biotechnology involved in identifying Human Immunodeficiency Virus (HIV). Nor did the NEP begin when health professionals drew attention to the connections between IDU, partners, sex workers, and clients. These happened several years before any need to legalise syringes was acknowledged.¹⁵⁸ In other societies the frameworks of understanding and

158. The work of framing barely started when authoritative bio-medical epidemiology 'pulled' Gay Related Immune Disorder (GRID) out from the messiness of life and up to a policy-making political elite as a newly labelled social problem. The framing gained traction when a contagious virus was eventually concluded to be the primary cause, and unsafe social practices to be the contributing causes. The framing gained further traction when it was realised that the heterosexual public was at risk, due to sexual transmission from heterosexual injecting drug users (IDU).

capabilities did not lead to the pattern of hybridity and peer involvement that has characterised the NEP. Instead, the NEP began when gay community organisers assumed control over public health campaigns against HIV/AIDS, becoming simultaneously vulnerable, expert, trusted, and empowered, problematising the meanings of private, public, health, and citizenship.

The first section of this chapter explores the local setting in which the NEP developed. This setting was constituted from the environments of state agency, professional, and harm reduction practices, while simultaneously being constituted from the institutions of medicine and crime. The second section describes how gay activist culture and community organisers responded to inaction by health professions and state agencies over HIV/AIDS prevention and homosexual law reform. The third section describes different frameworks of policy responses.

2 Gay peers link officials, medical professionals, and viruses

Licit syringe supply was inconceivable in New Zealand until the mid-1980s, when action in response to the threat of HIV/AIDS to the mainstream communities became an overwhelming priority for professional and political representatives. Previously, police, health groups, religious groups, traditional values groups, residents, educationalists, and many other mainstream lobbies opposed anything that might conceivably reduce the stigma and legal disincentives of illicit drug use. Syringe supply entailed unjustifiable career risks in what was then a stable employment, highly state-centralised¹⁵⁹ and professionalised health system. The concept of syringe supply was only accepted from overseas after new biomedical tests for HIV were available to provide reliable data for promoting evidence-based policy and models.¹⁶⁰ Such evidence allowed the opposition to syringe supply to be ‘put on trial’.

Modern societies have been characterised as alliances of state and profession, or of state agencies¹⁶¹

159. By centralised I mean that implementation was directly centred on state agencies and oversight. Later systems were contracted to and had funding supplied from central state agencies, but were not implemented by state officials or employees. Nor were the later systems reliant on professional medical personnel, since a model of administration had been replaced by a management model, and the managers were no longer required by legislation to hold professional medical qualifications. For example, hospitals in New Zealand became centralised in 1938, with the passing of the Social Security Act. Previous hospital developments had only been partially centrally funded, and was: “relatively haphazard, with the government being only one of a variety of providers, and with the establishment of hospitals being determined as much by local politics, political posturing and the influence of the medical professions, as by established need” (Gauld, 2001b: 220). The NEP, accordingly revisited or echoed a previous pattern of non-centralisation, yet not as ‘normal’ but as the ‘re-emergence’ of a forgotten past in the form of a forward-directed innovation responding to direct, immediate needs as much as to institutional frameworks of centralised official and professional systems.

160. Needle exchanges were ‘invented’ in Amsterdam in 1984, to reduce hepatitis B among IDU. In New Zealand, methadone supply programmes were considered to be, or at least presented as, curative treatments for drug use. Methadone was neither understood nor presented as a palliative treatment, involving harm reduction through maintenance. This may be because palliative treatment has only been considered ethical, from medical perspectives, when no curative treatment has been available. See Jenner (2001) for an ANT informed account of methadone in New Zealand. Van Kuppevelt (2000), has analysed Christchurch drug treatment centres.

161. I treat ‘a state’ as an ideal or evidenced entity of national governance. This is different from the production of ‘state

and professional bodies.¹⁶² State legislation protects professional jurisdictions from predation by competing occupations and other professions (Abbott, 1988, 1982), and from lay challenges over expertise and self-help. Professions 'package' their ethical, organising, expertise, wealth, status, and surveillance systems, all of which also support the capabilities and authority of state agencies. In the health area, these mutual dependencies are codified in legislation, beginning a 'modern health era' with the *Medical Act (1858)*, and supplementary legislation (Saks, 2002: 149-150).

Nonetheless, health professions also compete with state agencies over their degree of autonomy and the priority of ethical accountability (Stone, 2002), especially of control over regulations and financial remuneration.¹⁶³ State-professional relationships seem inherently complementary, since they cannot be separated, yet their productivity seems to derive from utilising their specialised differences in expertise, by means of actors who co-ordinate such differentials in unexceptional, everyday life.

New Zealand health professionals had followed international medical trends by medicalising unauthorised drug use, and by promoting the criminalisation of unauthorised drug use.¹⁶⁴ In New Zealand, as a variation on UK and US models, health professionals¹⁶⁵ claimed jurisdiction over treating drug users, similarly to the treatment of gays, for a succession of physiological, behavioural, and mental disorders.¹⁶⁶ These general disorders of drug use were also supposed to constitute or represent the illicit activities and desires of IDU.¹⁶⁷ Yet during the 1970s a multi-stranded, anti-authoritarian social movement which opposed medicalisation, while promoting the control of caring practices by consumers and patients, had emerged.¹⁶⁸ Gay rights and gay liberation movements also emerged during this period. Furthermore, after a period of stigma, the specialty of venereological began to be more professionally organised in New Zealand (Kampf, 2007). Certain disorders became more negotiable. Yet previous challenges to proper order and their settlement through corrective treatments and regimes became more complicated and problematic.

Self-help addiction groups had, decades earlier, challenged professional medicalisation from a lay

effects', through network connections of agencies that collectively align 'statable, statistical, and statemental' types of activity.

162. See Moran (2002), Ericson & Haggerty (1997: 69-70; 101, 111-114, 119), Johnson (1995), Beck (1992), Miller & Rose (1990), Menzies (1989), Abbott (1988: 30, 232, 320), Larson (1977).

163. See Allsop (2002: 79-93), Rosenbrock, Schaeffer, Dubois-Arber, Moers, Pinell, & Rosenthal (1995), Stacey (1992), Immergut (1992).

164. Refer ch. 1, sect. 2 & 3. See Davenport-Hines (2004: 365-375), Courtwright (2001, 1997, 1982), Marez (2004), Marks (1990a, 1990b), MacCoun & Reuter (2001).

165. Division of treatment expertise and organisation between clinician and addiction specialists, and between physiologists, counsellors, and mental health specialists, are too extensive and complex to describe here. Instead I use a general concept of interventionary treatment, either curative or palliative, for individual patients in a private relationship, in contrast with preventive expertise in public health relationships and public environments.

166. Such medicalisation of everyday life evokes comparisons with an earlier generation of medical professionals who medicalised masturbation, perhaps for similar sex-negative reasons associated with a cultural and legal heritage of western christian puritanism.

167. See Thom (2004: 17-24), Douglas (2002: 36-50, 149-152, 160-172), Douglas (1986), Courtwright (2001, 1997, 1982), Auerbach et al. (1994: 6-9), Zimring & Hawkins (1992), Zinberg (1984), Becker (1973). Many illustrations are found in recommended reading literature for professional drug treatment tertiary qualifications in general. Ghodse (2002: 1-10) offers a less biased guide than many. See also Davenport-Hines (2004: 294-383).

collective position through being financially self-supported if needed, by being residentially based, by defining addiction as an 'incurable disease', and by relying on faith in a 'higher power' (Ghodse, 1989: 142-147). Treatment specialists, in general, had not wished to claim such patient-centred terrain, yet could not offer better evidence of cures. Since both the lay and professional methods attracted dedicated practitioners, workable hybrid arrangements were negotiated in practice (Ghodse, 1989: 143). Despite the lay challenge to the boundaries of the area of professionalised treatment, both groups shared a common goal of 'religiously' espousing abstinence as constituting a defining criteria of wellness, while from a somewhat opposed framework, also providing the only cure for the 'disorder' of wanting to use drugs. The cultural circularity of this ideological concept created unlimited work for treatment professionals, but problematised evidence-based diagnosis and evaluation (Waller & Rumball, 2004: 23, 34).

Before HIV/AIDS became recognised, medical professionals, alongside practitioners who legitimised their work by means of biopsychological theories, had dominated the treatment of IDU in New Zealand.¹⁶⁹ These types of health expert claimed to represent the best interests of IDU when advocating abstinence-based treatments. However, mounting overseas evidence of the sexual transmission of HIV between IDU and non-IDU led to significant numbers of health specialists supporting the supply of syringes, even if these specialists did not support the treatment of drug problems through harm reduction methods and logics (Kemp, 1996). HIV/AIDS also fell partly within the territory of the existing speciality of sexually transmitted diseases (STDs). The history of STD treatment had oscillated between medicalisation and socialising. Medicalising was understood as tending towards private, individualising treatment even if subsidised by funding from state agencies. Socialising was understood as involving a public problem which required public health interventions and invoked a collective, moral framework of conduct.¹⁷⁰ This history involved stigma and patient blaming that engendered opposition, for instance when a Christchurch gay community centre was driven to operate its own STD clinic, separate from the moral agenda of the mainstream sexual health clinic. In 1982 the services of this gay STD clinic were extended to provide information about HIV/AIDS prevention (Parkinson & Hughes, 1987: 77-78).

Health specialists could efficiently access medical research from their overseas peers. An Auckland Hospital-based TaskForce began its collaboration on HIV between different medical specialities around 1983 (Lichtenstein, 1996: 412).¹⁷¹ The gay community responded more rapidly,¹⁷² with an

168. Neo-liberal, socialist, anarchist, radical, and conservative versions of feminisms have offered different critiques of the accountability of both professional and bureaucratic control. See Bunkle (1998), Libertarian Press (1991).

169. See Hannifin (1997), Van Kuppevelt (2000), and Jenner (2001: 19-21). Significant support for 'recovery' was offered by 12-steps groups. However, the disease model used by 12-steps groups was not accepted by many medical specialists, despite the support being acknowledged as contributing to better outcomes.

170. See Kampf (2007), Kehoe, (1987). The tactic of 'contact tracing' backed by powers of arrest and incarceration, as well as the forcible taking of samples without consent in prison situations, illustrates how the intersection of individualising and moral practices could be both an intensification yet also a deterrent to sentinel surveillance.

171. However, its earliest records in the National Archives date from October 1984 (AIDS TaskForce, 1984). In 1984, the newly elected government appointed a new Minister of Health, and radical state sector changes. Discrete liaisons

equivalent degree of access to research. This information was publicly disseminated in gay magazines such as *OUT!* and *Pink Triangle* (Parkinson & Hughes, 1987: 77-78), unlike the medical collegiate approaches.

Parkinson & Hughes (1987: 77-78) describe how in 1983 the National Gay Rights Coalition was resurrected with an HIV/AIDS focus, after going into recess in 1981. In Easter, 1984, a new grouping called the AIDS Support Network (ASN) emerged from the proceedings of a national seminar. The ASN gathered together many of the existing regional groups, such as the Auckland Gay Welfare Group and the Christchurch Gay Health Group. The ASN later restructured itself into the ASN Trust, which then changed its name to the New Zealand AIDS Foundation (NZAF). Since the NZAF was funded to represent and provide services for all people vulnerable to HIV/AIDS, it no longer represented gay-specific interests. Instead, the Gay TaskForce was created as a gay-specific representative group in 1985, working in close alliance with the NZAF on most issues (Parkinson & Hughes, 1987: 77-78).¹⁷³

Under the third National Government, led by Prime Minister Robert Muldoon from 1975 to 1984, gay community organisers produced leaflets and sent a delegate to an international conference, but received no funding, nor material support, nor formal recognition from the health officialdom, which lacked policy direction.¹⁷⁴ Nonetheless, the self-funded capabilities of gay organisations permitted health officials, some health professionals, and gay communities to take up policy positions that differed from mainstream public expectations. Yet health officials depended upon public understandings and political support to gain the resources and authority needed to directly implement policies, or direct professional agents. The 'spaces' of this policy differential opened up a resource for those people, activities, and environments most affected by the social interactivity of HIV/AIDS. Since hazardous practices needed to be decriminalised, according to some logics, yet were pressured to remain stigmatised or criminalised according to other logics, the institutional boundaries of crime, stigma, and status became more negotiable. These shifts were not necessarily extensive, nor foundational, but some created new opportunities for work. These opportunities responded to the needs of an environment that featured shifting boundaries of interactional practices.

By 1985, two separate groups had developed policy responses to HIV/AIDS. The process involved shaping themselves into collective infrastructures and accountabilities for delivering programmes

concealed under the previous government could then have suddenly emerged fully functioning. Certain health professionals also acknowledged an ethical requirement, unlike officialdom, to provide expert and timely health services, provided these services accorded with the precautionary principle of 'first do no harm'.

172. The initial New Zealand responses predated the identification in 1983 of HIV being the primary cause of AIDS.

173. Regional groups later emerged to provide alternatives to the state agency focus of the NZAF. These included the Auckland Community AIDS Services. Body Positive, which emerged later, focused on support and other grass-roots activities more than on national funding, policy input, and the co-ordination of education and prevention programmes (Lichtenstein, 1996: 384-385; Lindberg & McMorland, 1996).

174. See Parkinson & Hughes (1987: 77-78), Lichtenstein (1996: 383-386).

of care and advocacy. The first group consisted of those who organised within their local gay communities. Their organising patterns drew on gay rights models, then on the Shanti Project model from San Francisco (Parkinson & Hughes, 1987: 77-78). The Shanti Project was centred on peers 'giving care' to people with AIDS, as distinct from professionals 'providing expertise'. This type of community group was funded from within gay communities. As such groups became more experienced and effective they held national conferences and developed national facilitating structures. They rapidly extended their field of activity from ground-level responses within community networks, to include the mid-levels where health provision was strategised within specialised agencies. With no effective competition as service providers, they immediately formed close links with policy-making levels and national funding levels of health governance. The organisers had little previous experience of health sector politics, which differed in method from the gay liberation politics that had become familiar over the 1960s and 1970s.

The second group consisted of an informal network of treatment professionals. They had probably been communicating in a private, professional capacity. However their cross-specialty collaboration became shaped and stabilised when some, but not others, were invited by officials from the Division of Health Promotion to attend a meeting in Auckland to offer advice to the Department of Health as an informal TaskForce. Those selected constituted the AIDS TaskForce, which was based in Auckland Hospital.¹⁷⁵ This TaskForce was not formally linked to the Department, which was useful, since civil servants could not easily advocate for the reform of legislation. The TaskForce had greater freedoms of communication and was more insulated from Departmental politics, but was more directly accountable to the health professions which its members represented.

Officials, although qualified health professionals, were directly accountable to the government. In being a state agency, loyal to the government of the day, the Department was not necessarily trusted by the community organisers, health practitioners, medical professionals, and the general public. The officials, who represented state agency employers, could not condone illegal acts. Such officials were averse to negotiating with people such as gays and IDU who, quite publicly and blatantly, intended to commit crimes and who advocated for removing public order legislation that prohibited private consensual sex activities. For example, the first gay publication on HIV/AIDS was disclaimed by Department officials, who inspected the details of the publication for accuracy, but refused to be associated with an overtly gay enterprise.¹⁷⁶

175. According to national archive documents, their first recorded meeting was on the 15 October, 1984, after Labour had won the election from National (AIDS TaskForce, 1984). Other accounts suggest they first met around 1983. See (Department of Health (1985a), Holden (1985b), Bassett (1987a). There had been other taskforces set up in ad-hoc fashion, but no others were recognised as supported by the Department while not at all formally connected to the Department.

176. See Lindberg & McMorland (1996: 105-106), Parkinson & Hughes (1987: 78-79).

Although the Shanti Model initially focused on providing support care, its adherents also promoted effective public AIDS prevention programmes, as did the TaskForce. This goal required an initial evaluation of the conventional models of disease control. New Zealand legislation had prescribed forms of border control, isolation, quarantine, ‘cordon sanitaires’, and compulsory vaccination (Gray, 2006; Sewell, 1987: 43-44). Vaccination was clearly a non-issue, and it was generally agreed that border controls could need tightening. However, cordon sanitaires could not be practically defined, let alone enforced, when HIV was intermittently distributed and did not travel as a wave-front. The isolation of people diagnosed as HIV-positive, and the quarantine of people suspected of being potentially HIV-positive, from having already contracted the virus or through being liable to contract the virus due to their practices or reputation, would have seemed potentially useful, especially for reassuring the public. Yet enforced isolation and quarantine methods were not supported by medical specialists, nor public health officials. A number of factors were involved.

The transmission of HIV was through specific activities, such as sex and sharing injecting equipment, not through casual contacts, or merely being in someone’s general vicinity. This meant that quarantine could not be justified without labelling those quarantined as lacking in the capabilities or responsibilities for adult self-control and social morality. There were no medical treatments to cure or to eliminate infectiousness, which meant that incarceration in quarantine would apply for a person’s remaining lifetime, in some form of tax-funded custody, similar to the sanatoriums and leper colonies of previous eras.¹⁷⁷ The pragmatic difficulties in maintaining the infrastructures of systems of widespread, long-term segregation would be immense, as well as culturally unpalatable. Furthermore, most past episodes of national quarantine programmes were not considered highly effective.¹⁷⁸

The quarantining of a group of people for being social dangers, for example gays and sex workers, could not be effectively and efficiently enforced in a democratic liberal society. If IDU had not already been put in prison, they could hardly be quarantined. Yet the quarantine of HIV-positive people only could not be effective unless targeted on the basis of group identity, or by relying on large numbers of people to co-operate with the sentinel surveillance needed to identify those who were potentially contagious. Yet if imprisonment in a quarantine programme seemed a prospective outcome of surveillance testing, then the co-operation of those most needed to be compliant could not be ensured, making the expense of such programmes unjustifiable.

Quarantine and isolation programmes were thought likely to be demanded by many of the public for the satisfying of aesthetic and emotional prejudice.¹⁷⁹ But such programmes and prejudices

177. See Krieger & Appleman (1994), Nowak et al. (1991), Anderson & May (1988).

178. See Gray (2006), Sewell (1987: 43-44), Skegg (1987: 6).

179. See Lindberg & Johnstone (1987: 30), Sewell (1987: 44), Musto (1986). However, a public referendum to introduce quarantine legislation in California in 1986 had been lost by two to one. See Kirby (1988), Jayasuriya (1988), Lee S. (1987), Le Poire et al. (1990), Earickson (1990), Ranney (1987). Similar attitudes might well have been found in

were unjustifiable according to the rational, evidence-based planning methods which the officials and health specialists were required to employ. The only barriers which could be defended as effective in preventing HIV transmission were condoms, which required individual choice and motivation during a private social interaction. Quarantine risked excluding the person and driving the virus underground in many potential hosts. By contrast, a condom wordlessly asks those having sex to participate in isolating any viral risk, quarantining the virus and not the person. The combined condom and education approach promoted peer motivations towards individual accountability and choice, instead of reinforcing social barriers constructed from fear, secrecy, and stigma. Such logics and models of community-based motivation change, together with providing safer material environments, provided the goals towards which different medical, research, and community efforts became aligned, initially in San Francisco, then in New Zealand (Lindberg & Johnstone, 1987: 28-31).

3 Shaping the frameworks of policy responses

In 1983 Bruce Burnett returned to New Zealand with an AIDS Related Condition (ARC). Burnett had worked with the Shanti Project in San Francisco. Astonished by the lack of effort being applied to national organising in New Zealand¹⁸⁰ Burnett took on a commitment to remedy this situation. By 1984 he had promoted, assembled, and represented the network of regional AIDS support groups which named itself the AIDS Support Network (ASN). This community network requested and received stakeholder status with Department officials, who arranged for Burnett to attend the TaskForce meetings of biomedically qualified health professionals. Burnett represented gay communities, people with HIV/AIDS, and particular organisations, yet he has also represented lay people and communities in general. Moreover, he acted for a form of health care outside of state direction. This type of community care was a volatile, hopeful response to the deficiencies in the existing practices of professional care and epidemiological research.

The emphases on collectives and embedment contributed to a concept of 'environments of risk', as contrasted with individuals, groups, and practices of risks (Barnett & Whiteside, 2002: 81). The emphases in education and prevention shifted away from providing specific, time-limited interventions by outside experts, and towards providing social and material influences that were continuously reinforced by community peers. This type of service was not provided in the state sector and was perceived as conflicting with conventional priorities. For instance, after the Department paid Burnett to be an AIDS Support Network (ASN) educator and representative, certain medical specialists protested that health funds were misused by the employment of a lay

New Zealand.

180. Before 1984, New Zealanders were proud of their liberal socialist tradition of central government care for the needy.

community organiser “to educate people how to have safe sex and how to inject drugs safely” (Department of Health, 1985c). Department officials deflected this accusation by describing Burnett as contracted, rather than as representing the Department as a full employee.¹⁸¹ In an increasingly antagonistic environment, the distancing and impermanence of contractual relationships provided a mechanism of stability.

During his inaugural attendance at an AIDS TaskForce meeting, Burnett lectured the members on how: “gay men found difficulty in taking advice from the medical profession. Gays ... could not be motivated by fear. Such counselling required trained people” (AIDS TaskForce, 1984). This stance challenged established professional territories, especially that of venereology.¹⁸² Burnett was referring to how understandings of illness and death due to HIV/AIDS had been presented as biomedical facts which required behaviour change, yet were also associated with a history of medicalisation reinforced by puritanical attitudes to sexual desires.¹⁸³ Psychological diagnostic manuals had labelled gay desires and practices as harmful (Kirk & Kutchins, 1992: 179; Bayer, 1981), which had supported the criminalisation of gay men in codes of law (Logan, 1985) by those with religious and moral agendas. Venereologists were particularly distrusted by the gay community (Lichtenstein, 1996: 423).

Burnett and the AIDS Support Network (ASN) challenged the domination of HIV/AIDS policies and programmes by the medical professionals and biomedical expertise that constituted the AIDS TaskForce. According to then current institutional understandings, an STD was diagnosed through micro-organisms, but its spread was caused by the disordered behaviour and morals¹⁸⁴ of individuals, who consequently should be blamed and shamed as a public health component of their medical treatment.

However, the ASN re-presented HIV/AIDS as a social challenge, not merely another sexually transmitted disease. This stance reshaped general definitions and institutionalised understandings of diseases away from being essentially biomedical. That is, away from being limited to individuals or even ‘cases’ that excluded the whole patient from serious consideration except for the imposition of moral and behavioural demands for compliance. Instead of basing their approach on an ideological foundation of individualism and reductionism, the ASN applied a holistic method. This method emphasised the individual accountability needed for preventing HIV transmission, and expressed the goal of promoting quality in scientific research. Nevertheless, the ASN method allocated greater priority to ensuring the effectiveness of public health, education, and social interactions as a whole (Lindberg & Johnson, 1987: 28).

181. See AIDS TaskForce (1984), Department of Health (1985d).

182. See Lichtenstein (1996: 423-424), Logan (1985).

183. See Kampf, (2007), Kehoe (1987: 7), Lindberg & Johnstone (1987: 28-29).

184. A miscegenation of religious and secular puritanism seems involved. This framing of social problems as individual faults abetted religious stigma and presented homosexual law reform as a private rather than a public benefit.

Burnett and colleagues presented this biopsychosocial approach as a better foundation for HIV/AIDS prevention practice.¹⁸⁵ The experts in this method were not the bio-medical specialists in the scientific reductionism of clinical medicine, nor similarly reductionist bio-psychologists with their medicalised methods of defining normality and deviance. It was not made clear who did hold biopsychosocial expertise, but it was implied that skilled practitioners could be found or trained in New Zealand if a suitable policy and programme environment was created. This did not constitute a governance problem at state level because the general concept of community care and de-institutionalisation (Baker, 2002: 18) was acceptable to the fourth Labour Government. The way this biopsychosocial approach was presented blurred the boundaries between an actively caring community and a caste of qualified, career professionals.

The AIDS Support Network (ASN) pointed out how institutional attitudes contributed to the continuance and potential increase in the number of HIV/AIDS transmission. Since gay identity and sexual activity were often equated, frequent sex with multiple partners was seen as effectively a norm within gay culture (Parkinson, 1987a; Lindberg & Johnston, 1987: 28-30), regardless of legal prohibitions. Yet official or professional health advice on reducing transmission hazards during sex was suspect, because gays had well-established reasons to distrust the ignorance and fear the prejudices of health professionals (Parkinson, 1987a; Lindberg & Johnston, 1987: 28-30). As late as 1987, when the NEP infrastructure was being planned, gay community challenges to biomedical biases appeared in the *New Zealand Medical Journal* (Parkinson & Hughes, 1987), and Phil Parkinson informed a public symposium at the Auckland School of Medicine, that:

Even within the gay community in Wellington, I found that in a survey group of 78 mostly openly gay men, almost 20% had NOT [original emphasis] told their personal doctor of their orientation. A larger proportion had concealed this information from their doctor at a time when it might have been relevant to their health, usually in connection with stress and anxiety. Again, the reason is fear of what the doctor will think, and the possibility that they will receive inferior treatment because of the doctor's prejudice. And I'm sorry to say that some doctors are very prejudiced and very ignorant. ... only twenty years ago the American Medical Association still considered both homosexuals and masturbators to be mentally ill. No wonder the patients don't trust the doctors. ... I would urge all doctors who are involved in STD work to scrupulously avoid bringing their religious or moralistic prejudices, racism and or homophobia into the consultation with them. ... Do not stigmatise your patients, for by doing so you place them at increased risk. When we are labelled, we are no longer people, whether we wear a medical tag, a pink triangle, or a yellow star. (Parkinson, 1987b: 24-25)

Medical professionals on the AIDS TaskForce added to such distrust by refusing to support homosexual law reform, despite the physical harms caused by the criminalising of homosexual practices (Parkinson & Hughes, 1987: 79). Such general distrust was reinforced when a nurse refused care to the first person known to have AIDS in New Zealand (Parkinson & Hughes, 1987: 78). The professionalism which guaranteed the ethics and overall benefits of testing, whether in response to individual concerns or sentinel testing, was shown to be liable to prejudice and denial

185. See AIDS TaskForce (1985b), Burnett (1985), Clements (1985).

of care. The historical legacies of distrust were reinforced by current instances and fears that sentinel testing regimes would objectify and isolate individuals, and define gay communities from the outside, inviting stigma and other social dangers (Bayer & Kirp, 1992: 23-24). By contrast: “The risk reduction measures that appear to be responsible for the recent decline in the incidence of AIDS continue to be the most effective means to fight the epidemic” according to Burnett (1984, as cited in Parkinson & Hughes, 1987: 78).

Placing sole faith in bio-medical testing clearly required quarantine programmes to be effective, yet detracted from the community engagement and harm reduction prevention programmes. Burnett emphasised at a Venereology Conference in 1985 how: “the sociological and political aspects of the AIDS epidemic must be included in the medical response” (AIDS TaskForce, 1985b). A gay liberation slogan of the time consisted of ‘we are everywhere’. This pervasive yet invisible normality implied that programme administrators and official policy makers could not simply target well-identified gay groups for health education and screening. Such logics of control could not be expected to apply to a general population where those most likely to contract and spread HIV/AIDS were those most desirous of protecting their privacy from medical and related forms of official surveillance.

As Burnett pointed out to the TaskForce doctors: “80% of gays did not want to be identified and it was necessary to get in touch with them at a community level. ... the AIDS support network was strongly opposed to HTLV testing” (AIDS TaskForce, 1984). At this TaskForce meeting Burnett tabled an article extracted from the *New York Native Magazine* of 8 October 1984 which suggested that testing would only do harm to the position of gays in the community, while being useless in clinical and epidemiological terms. At the same TaskForce meeting, a proposed survey of 1000 gay men was abandoned because of practical and ethical difficulties, as well as the questionable value of the results from a non-random sample of only 20% of gays (AIDS Taskforce, 1984).

The AIDS Support Network (ASN) informed the TaskForce they were advising the gay public to preserve their personal and collective safety by boycotting general screening programmes at standard clinics.¹⁸⁶ Instead, the ASN would extend their own community-based education, counselling, and outreach services through their own clinics, staffed with professional employees and volunteers directly accountable to the ASN. Gay representatives such as Burnett attempted to minimise or control the potential harms of testing. They promoted a gay responsibility¹⁸⁷ to enhance community partnership by not donating blood, but they also challenged the accuracy, relevance, and social consequences of becoming subject to regimes of biomedical testing.

186. See AIDS TaskForce (1985c), Parkinson & Hughes (1987: 78).

187. Some North American gay groups argued for continuing to donate blood, since being excluded from the ‘public gift of life’ (Titmuss, 1997) reduced their civic status and human rights. This created a climate where non-gays increasingly demanded sentinel testing, not only of blood supplies, but of populations, as a public safety measure.

By publicising problems of trust and testing, by showing connections between moral prejudices and scientific medicine, and thus turning irrationalities of medical practice into a political and policy problem, Parkinson, Burnett, and colleagues directly undercut professional medical authority. This benefited health officials, who generally were required to reduce the control that health professionals could exert over health expenditure. IDU, who suffered as a group from refusing to comply with medical control of drugs, also benefited, since those particular cases of compliance with medical authority in treatment regimes thereby became excluded from IDU society. Officials could not ignore these activist, grass-roots criticisms because they were associated with groups that had already achieved measurable health promotion goals, with a greater expenditure of their own funds than the government had expended over the same period (Parkinson & Hughes, 1987).

The prevalence of HIV among IDU helped the AIDS Support Network (ASN) since venereologists, who could otherwise have claimed HIV/AIDS as falling within their professional territory, could not claim expert knowledge of drug injecting modes of transmission. Nor could Departmental officials claim any bureaucratic access to expert capabilities in the field of injecting drug use. Department officials, supported by Australian advice (Kirby, 1986), were aware that Police, Customs, Courts, and Corrections operations were incapable of stopping intravenous or other forms of drug use, or stopping drug users from having sex with non-drug users. The greater criminalising of IDU and greater vulnerability of sexworkers, compared with gays, were recognised in the New Zealand National Strategy.¹⁸⁸ Moreover, people attended venereological clinics to be cured. With no cure, there was no motivation to attend only to receive a medicalised sermon demanding they effectively stop being gay, or IDU.

The AIDS TaskForce responded to this challenge to medical and official governance in three ways. The first was to continue with standard biomedical models and public health organisations, using a minimal change model that I describe below. The second way involved promoting a biopsychosocial model, which used a new infrastructure to connect 'deviant' communities with health professionals and policy governance agencies. The third way consisted of denying or diluting the priority of the AIDS Support Network's critique by presenting religious, pastoral care as a socially legitimate alternative provider of health services. These responses illustrate how features of the institutional terrain in New Zealand were drawn into overt conflict by the need to reshape the boundaries around particular sites of care and deviance. The intensity of the public crisis, together with the obduracy of HIV and sex practices, led to the weakening of established boundaries between categories of care and deviance.

188. According to Lindberg, (1988 as cited in Lichtenstein, 1996: 390; Lindberg & Johnstone, 1987: 31). These comparisons emphasised the futility of driving gays back into the closet, where they would become as difficult to contact, motivate, regulate, and monitor as sexworkers and IDU.

One response of AIDS TaskForce members was to deny that gay communities and their representatives had a valid priority based on their greater vulnerability to the harms of HIV/AIDS. Several medical specialists on the TaskForce tried to establish what they claimed was a more valid, pluralistic form of community engagement. They presented 'non-judgemental Christianity', as a complementary priority. These specialists accused 'gay empowerment' concepts of dominating other perspectives, and argued for Christian counselling to also be supported (AIDS TaskForce, 1985d).

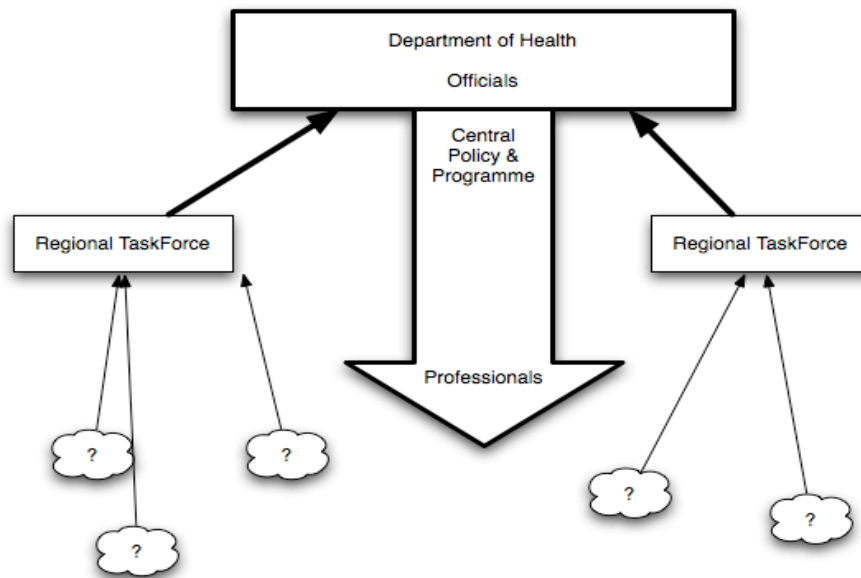
In February 1985 these specialists invited a pastor to attend a TaskForce meeting to apply for support “as a representative of Counsellors [sic] for non gay persons with AIDS or AIDS related queries” (AIDS TaskForce, 1985a). No reasons were recorded for non-Christian IDU, or non-gays, or different Christian denominations, to trust, or be motivated by, or accept being represented by a single Christian authority. This tactic, emerging from within the TaskForce, suggests reasons for the Minister and Department to increasingly appoint the membership of this high-profile, expert advisory group, rather than allowing or encouraging self-selection by professionals or their professional bodies on grounds limited to qualification and experience.

Nonetheless, the Minister’s selection of the expert, professional membership for religious and political reasons conflicted with the Ministerial stance that both social and scientific expertise was needed, but would be most effective and efficient in separate implementation and policy advice streams. This tactic also draws attention to the overlapping of Christian and medical professional networks. Although religion has been frequently presented as essentially private, and so irrelevant to medical expertise and social policy making,¹⁸⁹ that was not the case in the manoeuvrings of the TaskForce members. This overlapping becomes more significant later, because Christian organisations have generally opposed the decriminalisation of illicit drugs¹⁹⁰ even more than they have opposed the decriminalisation of homosexual practices.

A differing response to the gay community challenge involved AIDS TaskForce members attempting to retain control of health services provision by continuing with existing public health models, professional clinics, and official monopoly of decision-making. Dr. Ramirez, a member of the AIDS TaskForce, proposed that regional task-forces of medical practitioners would be employed by the Department. I interpret her model as requiring minimal changes to conventional arrangements, as in the following schematic.

189. For a strong counter argument with compelling evidence see Hager (2006). Hager analyses the covert influence of the Exclusive Brethren sect on political processes from which policy becomes legitimised as legislation.

190. There seems no fundamental reason for this in Christian scripture. There is a link between sex and drugs as forms of pleasure. There is also a strand of Christian belief and practice involving a ‘puritanical’ rejection of pleasure. Nonetheless, medical professionals are influenced by many factors, including a concern for evidence in decisionmaking. For instance, a survey in 1985 concluded that three-quarters of young clinical staff had used marijuana, and a group of younger doctors lobbied for decriminalisation, to the dismay of their professional body (Yska, 1990: 162-164) .



The proposed Regional TaskForces were to be hospital-based and primarily advisory, similar to the existing Auckland Hospital TaskForce. They would provide the epidemiological surveillance and co-ordination for evaluating needs and allocating existing types of resources efficiently (Ramirez, 1984). This approach combined public health models of prevention with medical models of treatment, in a single system that remained dominated by health professionals and health officials. This model seems a cost-effective extension of conventional health services provision. However, Hospital Board administrators highlighted underlying logical contradictions.

Such AIDS teams should become the responsibility of the local District Offices rather than the Medical Superintendent-in-Chief of a Hospital Board as the difficulties will occur in the private rather than the hospital sector. (Fairgray, 1985)

Moreover, the higher level medical specialists, who were more concerned about managing public panics and facilitating healthy relationships between the public, health professions, and health infrastructure, considered that many essential functions were not addressed, and could not be addressed, by any extension of standard practices of GP primary contact, specialised secondary treatment, and recovery support. Ramirez herself accepted that the support needs of AIDS patients “are expensive and involve numerous agencies and people and are therefore complex to organise efficiently” (Ramirez, 1984).

A month later, Dr Kent proposed that Regional AIDS Consultant Groups would each oversee an AIDS Clinic, initially a small pilot project. These Consultant Groups would include a representative from the Department, the local Area Health Board, blood donor services, Haemophilia Society, Gay Rights, Drug Abuse Centres, Social Workers, and an AIDS Referral group. The Clinic would liaise directly with these organisations (Kent, 1985). Kent’s system added

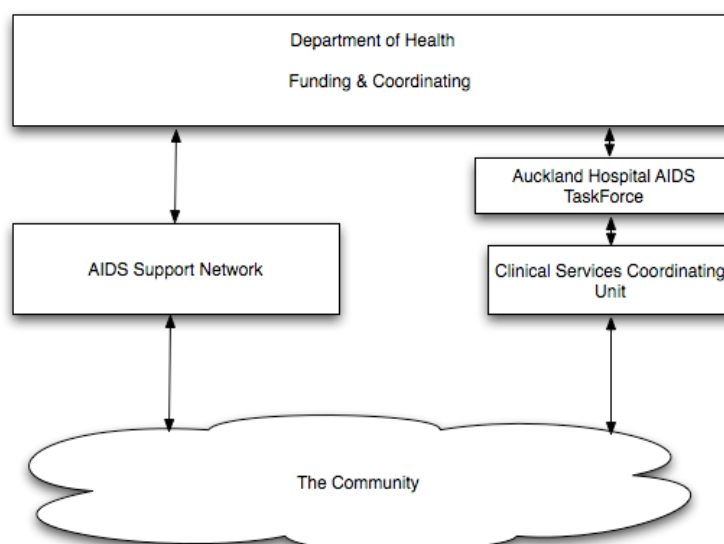
detail to the regional centres. It shifted from a medicalised focus towards wider community accountability and input, but only at regional levels. The Department's governance role was unspecified, as was how the Consultant Groups would advise, report on, audit, or manage 'their' AIDS clinic. Both Department and community were represented, but how policy and programmes would connect locally, regionally, and nationally was unspecified. Standard arrangements seemingly remained foundational.

Nonetheless, Kent's system included possibilities for separating the expertise located in the Clinic from the managerial issues of strategic governance of specific health organisations, from engaging with communities, and from co-ordinating a range of health specialities. Conventional forms of medical dominance would certainly be diluted and made accountable to a wider range of stakeholders than normal. Yet any representation from gay community organisers and drug treatment services would be readily outvoted by the health professionals. Since IDU engaged with personnel from drug treatment centres as enforcers of gate-keeping and treatment regimes, not as peers, the proposal was further stacked against community representation. At the time this would have seemed a reassuring aspect likely to attract support from health specialists, officials, and politicians.

The AIDS Support Network (ASN) counter-proposed a model featuring two parallel vertical 'channels' that connected the Department to the community.

The ASN Basic Model

Diagram 2:



Each channel connected a public 'pool' of health needs to the Department's funding and co-ordinating authority. In the left hand channel, the ASN liaised directly with the Department. In the accompanying text the ASN functions were described as controlling primary and public health

aspects of prevention, and directing policy over GPs and research. In the right hand channel, clinicians treated those patients who required interventions and intense support. In this diagram the ASN was drawn at an equivalent level to a Clinical Services Coordinating Unit directly under the Auckland Hospital in the right hand system (Burnett, 1985), but was less restrained in its vertical and horizontal scope, being New Zealand-wide.

Burnett noted that the ASN model of community service provision included the AIDS Referral Centres of Ramirez's practitioner-based model. However, directing policy over research and GPs would encourage the ASN to run its own clinics. The ASN would also direct existing aspects of primary health, such as GP and biomedical research. Burnett and the ASN did not aim for a separatist model. They wanted a pragmatic but radical shift.

There seems to be an attempt to segregate clinical aspects from the psycho-social; generally I think this is futile and dangerous. Apart from very specialised clinical aspects ... all discussion should include everyone. ... There was a general feeling among the community/lay representatives last time of an "orchestrated effort" to silence them and their concerns.
(Burnett, 1985)

The ASN model presented a clear programme for territorial expansion by community interests, and retraction of territorial claims by the conventional health professionals.

The AIDS Support Network (ASN) functions that were 'black-boxed' in the left hand channel, could be assumed to be complexly interactive, because aspects of medical policy combined with social policy and forms of implementation without precedent. This would require new work skills, start-up funding, pilot projects, and monitoring. The right hand channel functions seemed less complex, with well-tried types of organisation and expertise being extended somewhat. The diagram invited officials to attain the capabilities of the left hand path, but also to reduce the costs and encapsulate the accountabilities at a distance by contracting the arrangements to a non-government organisation, such as the ASN. The Kent model reduced professional dominance, but had not established a single, gay, community-oriented group as the crucial link between the Department of Health and all the non-treatment aspects of HIV/AIDS prevention. The ASN model did so in a way that clearly prevented professional practitioners from taking control of the community clinics and counselling sites where primary contacts and referrals would take place.

Ramirez responded by insisting that only a fully informed and qualified Medical Officer was capable of organising and providing the services of the 'AIDS referral centre' (Ramirez, 1985). This stance promoted medical expertise and official accountability, while undercutting the claim of the AIDS Support Network to holding greater expertise in community engagement. Nevertheless, the tactic and logics employed by Ramirez seem fatally flawed, since it required officials and politicians to assume political accountability for the private activities of gays. Gays were stigmatised. Homosexual practices were illegal. Yet prevention programmes needed to be trusted

by gays, because there was no prospect of a cure to pull them into treatment after becoming infected. The diagrams tell a story in which the price of retaining a wider separation between professional and lay claims to authority, while simultaneously protecting public health, was to cede professional territory.

These three proposals were presented to the TaskForce by its Chairperson, Dr Clements, in a way that recognised that one of two essentially different models needed to be prioritised. Dr. Clements stated:

While hospitals are undoubtedly going to have to respond to the need for admission of AIDS cases, there will equally surely be a need to sort out, diagnose, treat, counsel and reassure very many more people than simply those with AIDS. It is envisaged that the following will also seek help:

- 1 At risk groups
- 2 Contacts of known or suspected cases
- 3 Those with suspicious symptoms [sic]
- 4 Worried individuals from none of the above groups.

They will all need a range of services which may include:

- 1 Screening, surveillance or diagnosis
- 2 Outpatient treatment
- 3 Counselling
- 4 Contact tracing advice or service
- 5 Support
- 6 Education

In addition there needs to be a resource in main centres where individuals can be available for health education of community groups. Most of these activities could be usefully brought together in AIDS referral centres. These might be within the framework of the hospital's board or in the community and voluntary sector. (AIDS TaskForce, 1985b)

Dr Clements shifted the emphasis from clinics, with their medicalised expertise and hierarchal forms of administration, to a concept of 'referral centres', with information and people crossing lay-professional boundaries. He left open the question of the ownership of these centres, but knew very well that hospital administrators wanted no extra work, especially that involving private activities, perhaps illicit, with unclear funding arrangements and accountabilities. One administrator stated that involvement could: "overtax all in the hospital and local area. I fully realise the emotive appeal of AIDS and the need to prevent great emotional outbursts, but the number of cases is likely to be, hopefully, very small ... (Fairgray, 1985).

Dr Clements also knew that the shaping and stability of any health system depended upon funding systems, where funding streams and priorities might be altered by actors at key configurational points. He presented three funding alternatives, although the first seems a red herring. He stated to

the TaskForce:

Payment for services might be ... run predominantly by hospital boards with medical officer of health and voluntary agency assistance. Or it could be a departmental activity, the department paying contractual fees for services rendered - this would not easily fit any existing model. Another option would be to fund a voluntary body centrally who would contract out services as required. (AIDS TaskForce, 1985b)

Both of the two feasible funding options involved offering effective control of funding bottlenecks to agencies that might lie outside conventional medical professions or the official Department hierarchy. Dr Clements pointed out the potential problems of the Department becoming directly accountable for numerous regional contracts for experimental forms of services provision. This only left the 'voluntary body' option, as Dr Clement told the story.

The third response by AIDS TaskForce members to the gay community challenge was to accept the lack of capability of medical expertise and attempt to redress the situation in two ways. The first was to argue that law reform was an essential component of changing people's lifestyles towards safer practices. However, the influence of these particular members was insufficient to carry a proposal, on both compassionate and scientific grounds, that the TaskForce publicly recommend homosexual law reform (AIDS Taskforce, 1985c). The second tactic was aimed at expertise. Since HIV/AIDS was incurable, the palliative treatments of people with HIV/AIDS involved the organising of collective networks of care-givers over a patient's remaining lifetime. Burnett and several supportive members on the TaskForce therefore promoted a 'biopsychosocial model' over the biopsychological and the biomedical models.¹⁹¹

The initial biopsychological approaches to HIV prevention were conceptualised and implemented in terms of stages of rational control and understandings of individual patients (Auerbach et al., 1994: 5-9). Such methods drew on biomedical models of interventions by professional practitioners in clinical settings. Later methods utilised 'biopsychosocial models' of reciprocal relationships in wider environments which included life-worlds and life-phases.¹⁹² A biopsychosocial approach seemed better suited for support and prevention programmes, in being less interventionist, less reductionist, and more sensitive to differences in social environments. The approach included interactional models, concern with environments, and diffusion theory.

Some of the biopsychosocial interactional methods focused on micro-situations of understandings between emotionally linked people.¹⁹³ These therapy-oriented methods were nonetheless associated with community change (Aggleton, 1989). Environmental theories focused on social and material factors, such as the poverty, racism, employment, and the imprisonment that increased

191. See AIDS TaskForce (1985b), Clements (1985).

192. These environments included psychological and social interactions that influenced 'motivational challenges', while also being influenced by continuing interactions in life-worlds that might become internalised as 'normal'. See Waller & Rumball (2004: 23-25, 33, 39, 44), Engel (1982, 1980, 1977)

193. See Phillips (1988), Emmons et al. (1988), Shilts (1987).

marginalisation.¹⁹⁴ Diffusion Theory (Rogers, 1983) focused on how individual communication and action was embedded in the networks and foundational aspects of communities.¹⁹⁵

Burnett had pointed out that the TaskForce's biomedical expertise was inadequate when found unacceptable by those being 'treated'. He also showed that alternative logics and practices of interaction were available. However, the leading medical professionals on the TaskForce had shown they would strongly resist working in collaborative projects where their authority, expertise, methods, and recommendations would be evaluated from outside their circles of professional peers. Their separatist priorities were seen in the way the TaskForce members only reluctantly allowed Burnett to attend their meetings. Any proposals for participation by the representatives of marginalised communities and haemophiliacs was resisted. Even health professionals, such as nurses and public health officials, were excluded if considered too 'different'. Only in April 1988 was a Medical Officer of Health finally invited to join the AIDS Advisory Committee (Meech, 1988b, 1987c) which had carried on the TaskForce's functions. In 1988, according to Lindberg: "the only member not a doctor was Kate Leslie, a medical social worker" (1988, as cited in Lichtenstein, 1996: 386-387). The twenty-two doctors on the TaskForce unanimously: "agreed that the interests of haemophiliacs were well enough represented by Dr. [#] without the need for their representation on the Task Force which is primarily a technical committee" (AIDS TaskForce, 1985b). Arrangements involving any collaboration with political goals of homosexual law reform and social goals of community governance of health, would seem to threaten, by association, the expert status held by medical professionals.

Nevertheless, the AIDS Support Network representatives vehemently denied that a 'technical committee' could adequately represent the interests of an affected community. Lindberg and Johnstone emphasised that:

Heterosexuals have been telling homosexuals what to do for a long time, with disastrous [sic] consequences. Sex is that part of our lives that is most private, most personal, most surrounded with mystery and fear. Target groups must have a role in planning and carrying out their own campaigns within their own social group ... The role of the health professionals is to support community action. (Lindberg & Johnstone, 1987: 30)

Although focusing on sex, it is clear that other private, fearful, and mysterious aspects of identity and social practices would also contribute to marginalisation. Chronic diseases, such as haemophilia, sex work, and injecting drug practices, would all qualify.

The biopsychosocial model was promoted primarily as a workable adaptation to a society-wide problem, in the specific locality of health care, with a specific antagonist of biomedical dominance of the territory over community health. These principles were not founded on nor related to

194. See Ankrah (1989), Fineberg (1988), Gallo & Montagnier (1988), Freedman (1987), Pearson (1987).

195. For more recent diffusion theory relating to HIV/AIDS, see Rogers & Shefner-Rogers (1999). Rogers (1983) offers a perspective closer to the time of the NEP founding.

requirements for human rights or other universal ideals. The imperative that drove the lobbying and underpinned the need for change was primarily pragmatic. Nonetheless, there seems an implicitly political human rights and citizenship goal to be found in the pragmatic requirement for the empowerment of marginalised people and communities. The AIDS Support Network representatives made claims to public participation, based on pragmatic necessities of health governance, and were consequently offered a voice in an influential policy forum close to the political centre of state agency governance.

In March 1985, the Minister of Health agreed in a private meeting with Burnett, Logan, and two Department officials to make a financial grant to the AIDS Support Network, provided a Trust was established to administer the funds (Holden, 1985a). The AIDS Support Network had not received any previous government funding.¹⁹⁶ The AIDS Support Network Trust¹⁹⁷ was rapidly formed and received funding in May, not only for direct health provision, but also to meet the travel and research needs of liaising and directing HIV/AIDS policy (Holden, 1985a). In August 1985 the AIDS Support Network Trust renamed itself the New Zealand AIDS Foundation (NZAF). This pattern of organising that began as a network of community nodes had become in name, and actuality, a national scope and territory.

On the day the AIDS Support Network Trust deed was signed, the Minister's Advisory Committee on AIDS replaced the AIDS TaskForce. The AIDS Advisory Committee which succeeded the AIDS TaskForce held its initial meeting in July, chaired by Dr Meech¹⁹⁸ (AIDS Advisory Committee, 1985).¹⁹⁹ The Department of Health imposed the terms of the AIDS Advisory Committee after the AIDS TaskForce members refused to agree to support any that were proposed (Holden, 1985b). The new body was initially called an AIDS Taskforce, but soon was termed an 'advisory committee'. Presumably the term 'TaskForce' had become inappropriate. This AIDS Advisory Committee reported only through the Communicable Disease Control Advisory Committee of the Department of Health. It also offered Ministerial advice, but only on request. This prevented it from making media releases or presenting the Minister with unwelcome advice.

The Minister wanted different types of expert advice, but competing claims to knowledge, expressed within his solitary advisory committee, threatened constantly to erupt into politicised conflicts in a sensitive location. The expert committee was partly controlled as a private space for

196. Burnett had been individually employed in a consultant/liaison role while also representing the AIDS Support Network (Department of Health, 1985d). This expenditure had not been directly authorised by central agencies, and totalled less than \$7,000.

197. The 'AIDS Support Network Trust' was a separate legal entity from the AIDS Support Network.

198. Dr Meech was recorded as attending the first TaskForce meeting in October 1984 (AIDS TaskForce, 1984), but none of the following meetings.

199. Ten TaskForce members left, including two members who had criticised gay influence over the TaskForce. The secretary also changed. A Departmental secretary may have come to be considered appropriate. The chairman remained as a member, as did Dr Ellis-Peglar. Five others joined, all doctors, and the membership dropped from eleven to nine.

representatives of individual specialities to work in discrete collaboration, yet it was also a public platform from which politicised statements could be launched, and which constituted a tactical resource for aspiring projects of empowerment. The Minister needed to integrate the various types of knowledge into a pragmatic framework of workability and accountability. However, each type of specialist shared a professional interest in promoting their own biomedical frameworks and in excluding other perspectives.

The members of the initial TaskForce had begun to be appointed by the Minister himself. The Minister supposedly acted on the expert health advice of his Department (Department of Health, 1985a), despite the Department being bound to follow Ministerial direction. Such ambiguities illustrated conflicts of interests between officials and professionals. Some TaskForce members criticised the changes (Holden, 1985b), for instance, when the Division of Hospitals insisted that the Chair of the new (second) TaskForce not be a Department employee (Department of Health, 1985b). Equally significant conflicts positioned Christian against gay interests, as noted previously; and medical professionals against organised lay communities. The signing of the AIDS Support Network Trust deed, and the replacement of the AIDS TaskForce by the Minister's Advisory Committee on AIDS on the same day, formed a 'coupled' response to such conflicts over structure, methods, and representation. For instance, a senior Department official responded to protests by some medical professionals against Burnett's membership of the TaskForce with reassurances that the membership system was being changed.²⁰⁰ It was implied that the shift represented by the TaskForce turning into the expert advisory agency would prevent the sort of activities and publicity that Burnett had undertaken.

The new expert advisory agency was to specialise in controlled engagement with community and medical expertise. The distinction between the AIDS Support Network being non-funded, and the AIDS Support Network Trust receiving a \$100,000 grant (Department of Health, 1985d) can be understood as a selection and control mechanism. This mechanism separated medical professionals, peer community professionals, and officials²⁰¹ with formal boundaries. However, the mechanism also strengthened links of similarity between the gay community and conventional health service providers. In effect, the community, or its representative body, was moved towards more direct contact with funding agencies and legitimacy as a health service provider. Three weeks after the ASN Trust received \$100,000 as reimbursement and start-up funding from the government, the Minister signed-off \$345,440 as the initial funding for the ASN Trust to run an AIDS prevention campaign. This funding also illustrated the direct, top-down state authorising and organising of professional work opportunities, characteristic of European types of professionalism²⁰² where an

200. See Department of Health (1985c, 1985d). It was well-known that Burnett would not live long.

201. Later community representation on the AIDS Advisory Committee was by a single, professional, NZAF member.

202. See Le Bianic (2003), Freidson (2001), Abbott (1988: 161).

‘effect of state’ activity can emerge from a distributed network type of agency.²⁰³

The AIDS Advisory Committee was designed to be autonomous in its internal functioning, yet highly controlled by the Department and the Minister in its communications. The Committee was specifically defined as not being representative of communities, despite including a General Practitioner and an ASN Trust member as “representatives” (Department of Health, 1985b).²⁰⁴ The NZAF, by contrast, became a service delivery body that expertly represented consumers of health services along with communities affected by HIV/AIDS. Grass-roots community influences led to a multi-focused infrastructure that was centralised, yet promoted regional representation (Lindberg & McMorland (1996: 107-109).

I consider that the officials of the Department did not want any independent medical professionals contesting their advice to the Minister, offering different perspectives to the public, and complicating their arrangements to provide services through contracted agencies.²⁰⁵ Independent, professional quality, representation leading directly to the Minister from disorderly communities was equally undesired by these officials as well as by health professionals, despite their desire to research, monitor, and deliver services within such communities. The Minister needed to prevent contentious politics from emerging in his professional Advisory Committees, because divergent voices compromised the political authority and public stability provided by his enrolment of professional expertise alongside, yet conflicting with the tacit knowledge and direct engagement practices of community expertise.

Gays caused a problem for health officials by not following directives and by making political demands for support on gay rights issues. Gays caused problems for health professions by publicly rejecting specialist demands for trust, rejecting their expert methods, and rejecting the monopoly of a psycho-biomedical theoretical framework for policy-making. Although these rejections were applied to the single area of HIV/AIDS, this was a large and intense area in terms of public perception. The ASN Trust's inherent conflicts between representing different regions, and reducing differences in its community perspectives, became its private business rather than a

203. See Le Bianic (2003: 1-2), Immergut (1992). Le Bianic cites Abbott and Freidson as examples of an Anglo-American sociological perspective associated with a basic division between European and 'English-speaking' versions of state-society which includes characteristic types of professionalisation. Le Bianic critiques Anglo-American perspectives of treating 'the state' as a unitary actor from the perspective of professions, or systems of professions. In a case study of psychology in France, “The state apparatus comprises various segments, each acting in a different way towards the professions, and trying to promote a particular segment within the profession. ... states' policies towards professions are much more ‘anarchical’”. Accordingly, the significance of locality informs the theorising of professionalising processes.

204. This created the appearance that the Minister and medical professionals told several different stories about the supposed definition and terms of the Committee. On the other hand, the two representative positions might have been an attempt to incorporate two specific and forceful lobbying organisations, rather than communities. It seems that an indirect form of community/professional representation was wanted, but the appearance of direct and effective representation was shunned. There are clear managerial and electoral reasons for accessing expert information while rejecting any associated dependency.

205. No communicable diseases Taskforce seems to have existed until HIV/AIDS disrupted existing arrangements.

Ministerial, Departmental, or professional responsibility.²⁰⁶ Disorderly community voices from the ASN became re-ordered in a functional niche of contractual service delivery.

At the same time as a concept of 'gay community' was being redefined as a 'health care receiving' community, it also became redefined as a 'health care providing' community. Certain principles, such as the participation and empowerment of 'at risk' marginalised communities, became institutionalised during these conflicts. The conflicts cannot be considered separately from the alliances. Both need to be included in any characterisation of the shaping and sequencing of events as primarily driven by or producing a consensus. Because gays were distinct, due to being criminalised, medicalised, and stigmatised, they presented a problem for non-gays. Yet because 'they were everywhere', coexistent with those who considered themselves the mainstream community, their very normality constituted even more of a problem. The issue, and problems, seem characteristic of the hybridity of the situation.

Organising activities needed to act through representatives, because the sites of policy activity were 'owned', or limited in size, as, for instance, were the collections of officials who controlled access to Ministers and funding. This aspect of reduced scale and locale turned collective activity in other areas of wider scale into individualised activity, where chance, for instance the early death of Bruce Burnett, made a difference to the sequence and shaping of events. Long-term established players, such as Department officials, had interests in excluding individuals who refused to obey the rules, and who resisted exclusion by means of forming durable organisations that offered unique, essential services. These organisations attracted funding when official interests perceived these organisations as effective and efficient when controlled through their positioning as contractees, and when professionally corporatised as Trust Boards. These aspects suggest ways of thinking about links between scale, representation, and boundaries. The ASN Trust appears as a shaped and stabilised set of boundaries which emerged into wider recognition and negotiations, partly as an 'organisation', and partly as the exercise of a 'right' to participate. As Abbott (2001: 261-271) might suggest, in some ways the boundary shifting came first, part as possibility and part as seeding/ceding incidents amongst many other incidents that later appeared less significant than at the time. The initial boundary shifting then became more solid, before emerging as actual occurrences and experiences, as well as in the later retelling as events. As a result of organisational compromises pursued by the Department of Health in a series of pragmatic steps, the occupational form and boundaries of harm reduction work became significantly detached from the direct control of previously established players and from conventional institutions.

The implementation of New Zealand's HIV/AIDS strategy emerged from demands by the ASN for

206. This accommodation even lasted several years until 1988, when struggles between marginalised community representatives and professional health experts forced new adjustments with the splitting of the AIDS Advisory Committee into the National Council on AIDS and an appended Medical & Scientific Subcommittee.

community control of a parallel and autonomous system of professional health care. But was this implementation a type of management, or tactic, or a re-working of global to local models? I suggest the latter. By controlling the circulation of information at the mid-level of community networks, despite set-backs and opposition at advisory levels, gays who worked as HIV/AIDS programme organisers effectively controlled the policy configuration in the areas of greatest concern. In this way gays came via a health professionalising route to represent the public mainstream, in terms of its health, and for its own good. Gays effectively controlled public confidence in the authority of state agencies and health professional coalitions, as would any equivalently organised and motivated social movement.

These developments influenced the later NEP emergence and its peer-professional aspects through three well-evidenced types of activity. The records of how actors understood their options highlight the activity of temporal sequences, as in path-dependent constraints on possible actions. The records also show how actors established hopes and formal goals from desires and fears, and from trust and distrust. This activity involved general patterns of interactions, particularly the hybrid shapes between crime and health worlds. A third type of actant involved chance events, as in personal characteristics and biographical motivations for involvement. Path-dependencies, such as HIV/AIDS, become part of the landscape, continually and actively shaping developments while being used to 'explain' necessities and choices in terms of being natural or social. Chance events such as individual skills and charisma, might suddenly disappear and be no longer directly active, only influencing developments in terms of institutional path-dependency. In this manner the linking of a logos and a logic shifted into greater solidity in the form of a somewhat self-maintaining institution, or quasi-object.

In this chapter I have outlined the key actors who established the policy environment and organisations that influenced the later emergence of the NEP and its peer-professionals. I have shown the increasing status and utility of concepts of peer empowerment and harm reduction, as well as the blocking of religious and professional claims in areas characterised by private desires and decisions to reject puritan approaches to pleasure and risk. The alliances of community and official representatives have been accounted for, despite the inherent antagonisms between illicit gay practices and the requirement for officials to uphold the regime of law. In the following chapter I follow the broader environment of HIV/AIDS policy and organisational models, and specific advocacy by gay community organisers for a syringe supply system, to the situations where the NEP itself began to take a solid form during 1986.

From pharmacy to parliament

... it's about finding the creativities, the interesting cross-talks, ... a going-on-together that is less committed to death-defying heroics, more committed to mundane dailiness, more about the ordinary ethical accountabilities about life in these worlds which aren't all the time everywhere.

(How Like A Leaf. Donna Haraway, 2000b)

I have outlined where the logics of needle exchanges originated, and when their precedents were established, but why in particular places, and how were potential oppositions dealt with? I will describe in this chapter how a 'space'²⁰⁷ was constructed from, or between, pharmacies, overseas models, local gay organisations, gay IDU, key medical professionals, and health officials. This space consisted of patterns, permissions, and regulations over a harm reduction programme for IDU, forming a health jurisdiction. Unlike most spaces of regular health work and reliable funding, this was characterised by the absence of professional claims. Perhaps this is to be expected in a new health area. Yet the stages of spatial and motivational translation that explain the emergence of what was impossible in a single step involved strong professional influences. A discrete professional story appeared as part of a sequenced narrative event that became part of, and folded back into the actual and messier sequence of incidents and coincidence.

1 A new cycle - sex networks make syringes an official community problem

The initial HIV/AIDS organising had centred around the reformulation of professional, bureaucratic, and community claims over gay sexual activity. Proposals for tighter controls had been subverted by offers of community accountability, with a price-tag of community empowerment. However, by 1985 the overseas epidemiological literature indicated a potential for 'explosive' increases of HIV among IDU.²⁰⁸ This literature presented feasible links between IDU and wider populations, for instance through sex activities. New Zealand health professionals and officials also seemed influenced by a discrete, unspoken mutual need to minimise public panic. This need focused attention on how the needs and desires of IDU were to become formally linked to the official health policy in the context of HIV/AIDS.

The problems of offering health benefits to IDU had previously been explored in North America through debates over the provision of methadone maintenance programmes for treating or managing drug problems (Brette, 1991: 125-126). The issue firmed up as involving a conflict between health ethics and legislation. The requirements of medical ethics to provide evidence-

207. Such 'spaces' include physical, conceptual and representational locations of activity. They are not just 'places'.

208. See Kemp (1996: 153), Lungley & Baker (1989), World Health Organisation (1987: 3).

based treatment or other care to all, including IDU, conflicted with the requirements of medical professionalism to uphold laws prohibiting harmful or evil activities and so retain the confidence of public and politicians. In 1957 the Council on Mental Health of the American Medical Association admitted that such conflicts: "cannot be settled on the basis of objective facts", according to Dole & Nyswander (1985, as cited in Brett, 1991: 126). The health of society, understood according to non-objective frameworks of evaluation, was accepted as a professional rationale for 'rightfully' excluding IDU from the best practices of medical care.

An extreme example is found in the MK-ULTRA programme that involving experiments on humans, including patients and IDU, without informed consent.²⁰⁹ Such discrete, uneasy conflicts between health ethics and the perception of public interests were also found in New Zealand. For instance, until the 1980s venereologists 'examined' women inmates without medical need or informed consent (Kampf, 2007: 175-176). Yet in general, in New Zealand, IDU wanted supervised withdrawal and methadone maintenance treatment, but could not access these due to the low numbers of specialised clinics and the barriers put up by particular addiction treatment professionals.

When HIV/AIDS emerged as a social and physiological problem, the interventions proposed by the health professionals who claimed expertise in illicit drug use was initially limited to "advising drug abusers", along with "supporting suitable community groups" and "establishing confidential information and surveillance systems" (Department of Health, 1985e). The initial concepts in early 1985 were quite ambiguous, yet the proposed interventions into individual motivation changes were clearly prioritised over the interventions into community linkages:

Health education is defined as that which brings about behaviour change that improves individual and community health. ... Primary aims at preventing the individual from coming into contact with the AIDS virus. Secondary aims at limiting or preventing the spread from infected people to others.
(AIDS TaskForce, 1985b)

209. Such relationships between IDU and health professionals are further complexified by the participation of both in the MK-ULTRA programme in the 1950s. For example, one early MK-ULTRA funded study took place at the National Institute for Mental Health-Lexington Rehabilitation Center in Kentucky (Church Committee Report, 1976: 391-399). Addicts were supplied with their drug of addiction as a reward for being injected with hallucinogenic drugs, including LSD. Dr. Harris Isbell was one such doctor. He was employed by the CIA as well as being a member of the FDA's Advisory Committee on the Abuse of Depressant and Stimulant Drugs. Dr Isbell subjected inmates at the Addiction Research Center of the US Public Health Service Hospital in Lexington to intense biopsychosocial experimentation without the consent of the participants. The CIA funded these studies and archived the records. The CIA documents report that the subjects, who were nearly all black, received LSD for more than seventy-five consecutive days. See also commentaries by Marchetti & Marks (1974), Marks (1979), Lee & Shlain (2001), Blumsohn (2007). Some of the earlier records and commentary was known to my circle of anarchist IDU in Auckland and Christchurch in the 1980s. Such accounts continue to be corroborated by ongoing research. According to Blumsohn: "MK-ULTRA research was carried out with the quiet acquiescence of official medical bodies and with the active collaboration of many individual academics. Many individuals were awarded high honours, and no physicians were ever punished. Despite attempts to destroy MK-ULTRA records [Memorandum regarding destruction of MK-ULTRA documents in 1973 (1975), Summary Of Agency Records Retrieval (1994), Helms (1978)] much documentary evidence is available and the names of many of the involved academics, universities and hospitals are now known. On my way through MK-ULTRA documents I noted many names. A majority were doctors." (2007).

Education programmes were framed as primarily treatments, or as isolation from harm. Interactive public health then followed as a secondary approach. The more general concept prioritised 'reception prevention' over 'transmission and reception prevention'. A prescription for IDU followed:

Primary consists of stopping shooting. Secondary consists of stopping sharing syringes, stopping depositing semen in others, and encouraging condom use. (AIDS TaskForce, 1985b)

'Shooting' was presented as an individual activity, whereas sharing syringes and sex was presented as social interactivity. The more IDU-specific formulation for motivation change prioritised individual abstaining over safer using practices. The AIDS TaskForce could not prescribe abstinence as a 'prevention treatment' for gays (see previous chapter), yet tried to normalise abstinence as a prescription for IDU, as outlined in Table 1.

Table 1: Motivation Change Logics

Priority	General Goals	Implementation	Logics	Connotations
1°	Preventing individual risk of receiving HIV	Abstain from: injecting drug use? But not from: gay sex practices?	Opposed logics Different models	- Motivation change only - Treatment expertise needed - Prolonged intervention? - Intensive intervention? - Expensive?
2°	Preventing HIV social links through objects	Safer: injecting practices? As well as: gay sex practices?	Aligned logics Similar models	- Motivation change also - Environment change - Public health expertise - Education required? - Trust required? - Focus on objects

The framing of the AIDS TaskForce proposal referred to the objects in IDU-HIV networks, such as syringes, semen, and condoms, in terms of social interactions rather than availability. Bleach became the initial type of injection 'equipment' to challenge prohibition laws. As with public sex education on illicit homosexual acts (AIDS TaskForce, 1985c), advocating the use and supply of bleach led to unease but was not interpreted as illegal. Nor were police and treatment specialists recorded as opposing proposals for the Department to publish information on sterilising syringes with bleach. But an uneasy tone was apparent in those discussions, and proposed policies that involved the direct provision of bleach were rejected.²¹⁰

Despite the unease over directly supplying bleach, the AIDS TaskForce placed the concept of supplying sterile injecting equipment on its list of policy options that had been tested overseas. My interpretation is that directly supplying bleach involved immediate costs to the proponents of an

210. See Lungley & Baker (1989: 39). I heard anecdotal accounts during that period that bleach was sometimes found in prisons, but this depended on informal work-arounds and the attitudes of particular staff.

under-resourced policy initiative. By contrast, a deferred, clearly slower moving proposal to institute a formal programme of syringe supply provided the time to gather momentum and status in a state-by-stage development. Bleach was simpler to provide than syringes, in fact too simple given the institutional difficulties needing to be overcome or reconfigured. The interplay of resources and risks have seemed important, but the timing even more so. Earlier debates, strategies, and organising models preceded and shaped the environment for successive developments and reshaping of new conflicts.

As with the earlier cycle of sex-oriented prevention programmes, staged policy developments were notable (Plumridge and Chetwynd, 1994: 289), where planning and community responses both influenced the timing and shaping of official policy responses. In mid-1985, Burnett had publicly called for safe injecting education (Department of Health, 1985c). In March 1985, Redmer Yska, a journalist who later became the Minister's Press secretary (Yska, 2007) made an appointment to see the Minister of Health to discuss issues of injecting drug hazards raised in *TOM*, a Wellington urban culture magazine:

Unlike Australia, the United Kingdom, and the U.S.A., no chemist in New Zealand will sell a syringe to someone he suspects is a junkie. AIDS would scythe through Auckland's junkie population in a couple of weeks. Who knows - maybe it already has. ... pharmaceutical narcotics and clean equipment must be supplied to addicts on a controlled basis at approved clinics. (Anon., 1985)²¹¹

The Minister gave sufficient credence to this article, and to the journalistic sources not accessible by the Department officials, to agree to the personal meeting (Yska, 2003 pers. com.). It became clear from such sources that an illicit form of syringe supply clinic already operated. Between 1985 and 1986, several pharmacists sold syringes, against the dictates of their professional bodies and legislation.²¹² These sales showed that many IDU accepted a user-pays system and their custom did not disrupt business.²¹³ Yet the handful of pharmacists involved illicitly was unlikely to increase in number without syringes being decriminalised or legalised syringes. Some medical specialists interpreted syringe supply as opposing their professional ethics and interests by causing harm, even if indirectly.²¹⁴

211. "A decade ago opiates were pretty freely available ... thousands tried heroin at least once. By 1980, hard drugs were all but finished ... The early 1980's saw the junkie population enjoying locally grown poppies and another "completely non-addictive painkiller" called Temgesic or Buprenorphine which was abused so much by young needlers it had to be reclassified. ... And so to homebake which really peaked in 1984 with hundreds involved in the main centres. ... Meantime the "sleeping" junkies of the 1970's are crowding back into the drug clinics for treatment. Re-hooked on all that spare 'bake ... More disturbingly homebake has brought back the needle. And most hypodermics are blood-caked and dirty as hell. ..." (Anon., 1985: 1).

212. The police turned a blind eye, but some Christian pharmacists from Dunedin arranged for a Christchurch pharmacist to obtain proof of sales and lay a formal complaint before their professional disciplinary board. See Lee (1987: 114-115), Mainline (2003a, b). See also Baker (1987a: 73), Moffett (1987a, 1988), Pollard (1988). Pollard was found in breach of professional codes of conduct, censured, and fined. However the Christchurch City Council formally honoured Pollard for his contributions to public safety. Pharmacist opposition to any involvement with the NEP had been strongest in the southern half of the South Island. See Donoghue (1987a, b).

213. This was feared, due to cultural stigma reinforced by interested groups who attribute social isolation, incompetence, nihilism, and ritualism to IDU. The situation seems related to the stigma and opportunism, if not exploitation, of the mentally ill and those born less capable, whose social desires are also frequently treated as outside of human needs.

A syringe supply policy was initially introduced, reluctantly, by the Drugs Advisory Committee²¹⁵ in a paper for the AIDS Advisory Committee (1985). This paper described IDU generally as irrational, and as ritually sharing syringes, but did not cite any studies of New Zealand IDU to support these claims. The paper did however formally note the harms caused by sterile syringes being inaccessible, especially in prisons.²¹⁶ The paper warned against the prospective harms of condoning or encouraging IV drug use and recommended counselling to compensate. This counselling was presented as conventional and professional, required by but not complementing syringe supply.

By July 1985, support for 'community engaged counselling' had appeared in the formal Departmental policy advice (Department of Health, 1985e). Community groups became considered as potentially useful sources of information, but were not specified as potential sources of professional service delivery. Instead, an ambiguously named 'community engaged counselling' was referred to in a professional context, but was not defined as a skill-set, or as an agency type, or as an infrastructure to provide access and monitoring. No public IDU organisations then existed in New Zealand.

Professional medical expertise was publicly mobilised in alliance with official policies to support the proposed legislation changes and to establish an infrastructure for the supply of syringes. However, the market logistics and political logics did not necessarily align with the health professional logics of independence and the occupational control of territory. The goals and rationales differed to greatly for the different elements to simply fall into alignment. These differences were bridged, or evaded, by the exertions of a semiformal Ministerial team consisting of the Minister of Health, Michael Bassett, his new Press Secretary, Redmer Yska,²¹⁷ and his Special Medical Aide, Dr. Michael Baker. This team linked political, drug-using, and official worlds by means of its greater freedom of action and fewer long-term constraints (State Services Commission, 1995: 25) than the systems they mobilised. As with Burnett, and later Rodger Wright, this team was short-term, and more 'nomadic' than institution or career-oriented. They occupied a

214. See later sections in this chapter on opposition to the NEP amendments to the Misuse of Drugs and Health Acts. Strangely, whereas public health proponents frequently argue in absolutist terms of providing unambiguous health benefits through monitoring public actions, often shifting boundaries to include what many people consider private, medical and surgical specialists have generally accepted that any health intervention includes a component of harm, or risk, hopefully outweighed by benefits. Yet the NEP was planned by public health specialists according to harm reduction logics of balancing harms and benefits, while many opponents came from medical specialty areas and argued in terms of absolutes, not skilled discretionary judgement of costs and benefits.

215. The Drugs Advisory Committee, was established in 1980 as a ministerial committee offering advice on illicit drug policy. It came to promote a national cannabis policy that would link with policy on licit drugs, rather than treating crime and health aspects as separate (Abel & Casswell, 1998).

216. For an overview of changes in prison policy in New Zealand, see Newbold (2007).

217. Yska has worked as a journalist (Yska, 2007). He also published a book on the history of marijuana in New Zealand (Yska, 1990). He has published a social history of the emergence of youth and music culture in New Zealand in *All Shook Up: The Flash Bodgie and the Rise of the New Zealand Teenager in the Fifties* (Yska, 1993). His history of the city of Wellington (Yska, 2006), was well-received (Black, 2006). Yska has also published a social history of the emergence of the New Zealand teenager alongside a youth genre of popular music (1993).

single key space of activity. Each team member drew on their personal connections and expertise as a NEP Management Plan was assembled, decriminalisation amendments to the Misuse of Drugs Act were drafted, and a set of regulations was developed to work within the shelter of a slightly modified Health Act.

A different set of actors formed into the ‘Intravenous League’ (IV League) group. Like the ASN, this represented an illicit community, but was far smaller. In 1985 (Mainline, 2003c), or by another account, in mid-1986 (Kemp, 1996: 154), the IV League was constituted from a small group of IDU, and received advice from a handful of supportive medical practitioners (Robinson, 1990). Its spokespersons were Gary McGrath and Rodger Wright (Mainline, 2003b; Wright, 1993, 1990) who, like Burnett, were gay and HIV-positive. The IV League was quietly encouraged by the Ministerial action team, and Yska probably suggested its name (Baker, 2002, pers. com.). The IV League helped to convince politicians and pharmacists that IDU were not, as caricatured, careless of their lives and health.²¹⁸ The personal testimony of League members added to local research (Robinson, Thornton, Rout, & Mackenzie, 1987), to show that IDU re-used syringes from necessity alone, not for irrational or ritual reasons.

We find it terrifying that not only our lifestyles but also our lives are virtually held ransom. It is especially disturbing to hear terms such as “guilty victims” being bandied about by ‘moralists’ (and I use the term loosely and advisedly) who would rather see no help given us, let us die a most horrible death than to see us survive. Ten years ago homosexuals were in this position, no-one would dare to be so silly as to suggest that now. Instead it is the time for ‘junkies’. The last (or nearly the last) social group that can be killed off, in the manner described above, quite legitimately, by people who are far to [sic] sanctimoniously smug to recognise the dangers AIDS presents to all New Zealanders. (Moran & Finlay, 1987)

The League did not directly confront medical authority over the accessibility and standards of drug treatments, but did discount medical expertise in the areas of prevention of drug use and the reduction of harmful practices. These arguments followed directly from the community distrust of medical expertise, as previously articulated by Burnett and others in the AID Support Network. The League made direct linkages between homosexuals and IDU when promoting syringe supply. The League did not just follow the gay community concerns, but also introduced a new concern, particular to blood-to-blood practices, of a disease agent later to be called HCV. In 1987, League members warned, far in advance of the later concerns of professionals, officials, and economists, that: “People are in grave danger of contracting not only AIDS but also Hepatitis A and B and the new strain: non A/non B. Surely the change and legalisation of purchase can be hastened?” (Moran & Finlay, 1987).

The League focused first on normalising²¹⁹ the participation of IDU in health policy, secondly on

218. See Caygill (1987b), McGrath (1987), Wright (1987), Berks (1988), Kerse (1988e), Kemp (1996, 2004).

219. This is normalisation of persons as citizens, for whom normal chances for living should be offered, in the Netherlands sense (Waller & Rumball, 2004: 33), rather than of increasing drug prevalence or use in the UK sense (Parker, Williams & Aldridge, 2002; Parker et al., 1998).

IDU participation in health provision. The League did not prioritise general IDU rights, nor decriminalisation, though these were supported by many members. This enabled the League to avoid direct clashes over inherent differences in interests with the state legal apparatus, and with the drug treatment sector. The League asked for state support, being careful to specify ways in which such support could be evaluated and legitimised. For instance, the League did not want to run its own service providing agency. Instead it promoted Departmental programmes which the League would only have policy input into. The League was similar to the ASN in desiring a relationship with state agencies, but differed by avoiding issues of decriminalisation, being low in membership, and holding no aspirations to become a service provider.

The principles of participation and accessibility to monitoring that Department officials and professionals had developed with the ASN were readily transposed to the IV League, even though the aspirations and defining habits of gays and IDU were in many ways very different. Injecting drug use might overlap with gay cultural practices, but to no significant extent. The crucial aspect lay not in these differences, but in the similarities of stigma and secrecy, in the similarity of vulnerability to HIV/AIDS, and in the similarity of potential transmission to wider, mainstream populations. The health policy makers were persuaded that the similarity was significant. Nonetheless, the police administrators zealously opposed decriminalising any part of illicit drug use.

However, by 1986, a growing body of evidence from overseas indicated that needle exchanges achieved a consistent and significant reduction in HIV transmission among IDU, while not increasing any drug related problems. Evidence from Amsterdam had arrived by June (Buning et al., 1986); from Scotland by September (*Precis of HIV Infection In Scotland*, 1986); and from Australia by November when a paper from Kate Dolan reported on the feasibility of a Needle Exchange Scheme (Dolan, 1986). A later police crackdown on drug use and syringe possession in Edinburgh caused shooting galleries to re-emerge, along with a well-monitored increase in HIV incidence.²²⁰ This body of evidence forced policy makers to compare two types of harm, with the decriminalising of syringes in needle exchanges seeming less harmful than the deaths of IDU. The conventional treatment policy was aimed at 'saving' IDU, but a dead IDU could neither be treated nor 'saved'. Furthermore, until they died, an IDU could pass HIV to others, not just to other IDU via shared injecting equipment, but also to non-IDU through sexual connections or vertical transmission from mother to baby.²²¹ Health professionals and Department officials in New Zealand acknowledged that they needed to motivate IDU to reduce the public harms potentially caused by their private activities. In the face of both moral and pragmatic reasons, even the New Zealand police administrators were persuaded to withdraw their previous vehement opposition to

220. See Massam (1986) 1-4; *Precis of HIV Infection in Scotland* (1986); Davenport-Hines (2004: 379).

221. For discussion of 'innocent victims' see Lichtenstein (1996).

supplying syringes.

Between November 1986 and January 1987 the AIDS Advisory Committee recommended that a syringe exchange system should be developed to increase contact between IDU and education/prevention counselling.²²² The Minister, rather hesitantly, came to promote the concept in public in January (Bassett, 1987a), after consulting with and receiving crucial support from Caucus peers, notably from Judy Keall (Bassett, 2002. pers. com.; Yska, 2003. pers. com.). The Minister had also received a supportive review of the Sydney syringe exchange pilot study (Dolan, 1986), which included encouragement from Dr Wodak.

Over the period that the syringe supply policy coalesced, health and policing experts were unable to design a comprehensive treatment or prevention programme, for several reasons. Their mutual association in promoting law enforcement prevented accurate demographic and epidemiological data being gathered.²²³ Professional expertise could neither cure AIDS, nor vaccinate for HIV, nor treat drug problems more reliably than the faith-based self-help groups, the individual-focused 'rational withdrawal' methods, or simply growing out of a drug-using career.²²⁴ Overlapping and sometimes conflicting models of drug use were employed by professional treatment practitioners.²²⁵ Myths about IDU permeated the expert advice while carrying a contagious cargo of stigma. Such stigmatising myths included medical misinformation that IDU shared syringes for ritual reasons, that IDU were socially isolated, and that IDU were asexual apart from sex-work. The lack of reliable data on IDU numbers and practices, in conjunction with the known need of IDU for anonymity, ensured that community work was not directly integrated with the syringe supply aspect of the NEP planning. By leaving ambiguous the monitoring, activities, and nature of IDU community groups, the rigorous syringe supply plan was more capable of maintaining the enrolment of the key stakeholders, any of whose committed veto could destroy the planning.

222. See Bassett (1987a, as cited in Baker, 1987a), Meech (1987d).

223. See Kemp (1996), Zimring & Hawkins (1992: 29-31), Lungley & Baker (1989: 38).

224. See Waller & Rumball (2004: 15-16, 23, 34), Cornwell (2003: 582), Austrian (1995: 129).

225. See Courtwright (1982) for overlapping histories of treatment regimes in North America. These frameworks include moral vice (emphasises hedonism and issues of control); inadequate medical control (emphasises over-prescribing by doctors, and training of doctors); inherited physiological propensity/disorder (tries to explain why some drug users succeed in control and others do not); iatrogenic exposure to addictive substances (emphasises dual diagnosis and self-medication); psychiatric psychosis (this became popular after changes in class, race and geographies of patient demographics). See Zinberg (1984) for later 'drug, set and setting' concept. See Ghodse (1989: 7-25) for a UK perspective at the time of NEP developments. See Zimring & Hawkins (1992) for North American perspectives. For a rather exaggerated essay by a UK prison doctor and psychiatrist who criticises an alliance of interests between injecting opiate users and treatment professionals, see Dalrymple [Daniels], 2006. Dalrymple seems justified in pointing out this alliance, but not in treating the groups involved as monolithic, especially in the assumption that the pain of opiate withdrawal is effectively the same for all.

2 Who was to provide the NEP infrastructure?

Having received Caucus and Cabinet²²⁶ endorsement, the Minister then formally asked the AIDS Advisory Committee to seek evidence that could support a licit syringe supply programme and any associated legislative change. Previous reports from the Departmental had supported needle exchanges and harm reduction logics in concept, but the Department officials required Ministerial direction before publicly criticising the existing legislation (State Services Commission, 1995: 38) that prevented an official programme from functioning. Once the Minister had taken a formal stance, his sources of official and professional health expertise became far more closely aligned with his three-person Taskforce, his political colleagues, and the IDU community representatives. This alignment of goals and collaboration in method between different specialties constituted an articulation, as in a mechanism that brought about and explains such organised social activity. This activity began to sketchily outline the unstated and unrealised proto-boundaries of the NEP.

The support from Cabinet formed a crucial passage point²²⁷ for inter-departmental consultation. Between the 12th and 19th of February an inter-departmental working party, including Police and Customs members but dominated by Health officials, evaluated a shortlist of service delivery mechanisms provided by Health Department staff. This working party discussed three general policy responses to clarify goals and constraints, including the option of doing nothing. Three implementation methods were selected for further comment by various government agencies. This short-list featured mobile units, established clinics and medical practices, and pharmacies, as summarised in Table 2 below.

Table 2: Shortlist of NEP Options

Type of Site?	Type of activity?	Costing at Startup?	Costing Per Annum?	Police approval?	Counselling?	Recommendation
Mobile unit.	Limited clinic services.	\$190,000	\$750,100	No.	Yes.	Rejected.
A new type of clinic.				Fears of public acceptability.	AAC supported.	Adjunct services only.
Established drug clinics, medical practices & GPs.	Full general health. Specialising in drug treatment.	\$460,000	\$400,000	Yes.	Yes. AAC supported.	Possibly. Supported by all parties.
Pharmacies.	Full national dispensary coverage.	None. Cheapest.	\$93,000 Cheapest.	No. But objections later decreased.	Referral only. Not AAC supported.	Possibly. Health specialist support, but not Police, nor AAC.

Two clinic-type options appeared on the short-list, but neither was considered feasible, due primarily to their high costs.²²⁸ Clinics were well-established, and well-understood as sites where

226. That the Minister had not been personally opposed to the NEP and harm reduction logics is shown by his early interest in the *TOM* article drawn to his attention by Yska, and employment of Yska as his Press Secretary. Bassett was relieved to find that no objections emerged (Bassett, 2002 pers. com.)

227. See Callon (1999, 1991), Callon et al. (1997), Latour (1988: 43).

professional medical expertise would be centred and strongly resourced. However, there were insufficient existing clinics with the appropriate expertise and experience of IDU to provide national coverage.²²⁹ The AIDS Advisory Committee favoured the provision of clinics of some sort to guarantee the availability of point-of-sale counselling as well as a wide coverage with a broad range of services. However, the Advisory Committee could not argue convincingly that cost-effective geographical coverage would be provided through existing or newly established clinics. This led to exploring the option of mobile clinics that offered greater geographical coverage.

The New Zealand Medical Association understood that the AIDS Advisory Committee had strongly promoted the development of mobile clinics with the necessary staff and facilities (Baird, 1987). However, both the IV League and police stated that mobile clinics would be too easily identified, would not be accepted by the public, and would not be accepted by IDU due to the threat to their anonymity (McGrath, 1987: 2); Stoke, 1987a). Several factors argued against using established treatment clinics, mobile or otherwise. Conventional clinics were labour intensive at a time of increasing political sensitivities over hospital waiting lists and costs. The treatment policies at clinics emphasised obligatory abstinence from drug use, yet the policies on AIDS emphasised that, while individuals needed to become accountable for preventing HIV transmission, nevertheless motivation changes could not be forced, nor induced through fear.

The Department officials invited the managers of drug treatment clinics to participate in the planning and implementation of the syringe supply scheme. However, those that responded refused to participate in any policies and programmes that challenged the abstinence logics of their treatment methods (Meech, 1987b). They offered, notwithstanding, to continue trying to reduce the numbers of IDU through treatment, and welcomed any extra funding towards this ideal. This stance indicates a degree of competition for funding from methods recognised as completely inadequate for HIV/AIDS prevention among gay men or IDU. Although members of the public consistently called for the supply of syringe to be restricted to drug treatment clinics, the Department officials rejected such scenarios as unworkable.

The working party which evaluated the range of potential NEP infrastructures rejected mobile clinics, and recommended delaying any decision between the established clinics and pharmacies. Various paradoxes and conflicts had emerged in the engagements between the hierarchies of officials, the professions of medicine, and the private networks of IDU. These difficulties combined with the need for low start-up costs to favour pragmatic proposals.²³⁰ The most pragmatic

228. These costs rose significantly over the planning period. Initial costings were found to be underestimates. The dislike by the police for one clinic option seems less significant because the police also objected to the pharmacy option eventually chosen, although their objections to pharmacies had later reduced.

229. This problem was magnified by the development of 'home-baking' forms of opiate drug supply and demand in cities, followed by the emigration of these practices into small towns. See McGrath (1987: 1), Lee (1987).

230. Baker (2002 pers. com.) said that he enjoyed working with the pragmatic, 'make-it-work' attitudes of pharmacists.

system seemed a user-pays framework of logistics and information. This was also the most self-funding and cheapest to administer system. The demand from IDU customers could replace the top-down infrastructure of skilled disbursers requiring supervisory management in an employment pyramid. This user-pays aspects²³¹ sheltered the NEP from accusations of misusing public taxes, and pushed many hybrid problems arising from mixing illicit and professional health systems out of sight. The user-pays aspects also positioned IDU as competent, independent, normal customers of a normal business arrangements.²³²

The support from pharmacists was initially uncertain. Large sections of their profession were opposed to being involved in syringe supply (Lungley & Baker, 1989: 39). Some pharmacists felt that involvement would compromise their high status, authoritative, law-enforcing image, and would undercut existing client relationships. Nonetheless, the pharmacy environment was conducive to participation. Ever since the 1930s, pharmacists had monopolised the jurisdiction to dispense medications, to own pharmacies, and to run retail pharmaceutical businesses. This jurisdiction involved regulations that required pharmacists to run only a single business, rather than a chain, thereby causing an oversupply of qualified personnel (Moffett, 1987b: 14-15). Yet market-based restructuring, following the nation-wide neo-liberal changes,²³³ threatened many individual pharmacies with closures and with layoffs from assimilation by supermarket chains and franchise outlets. The pharmacist leaders therefore opposed being defined as essentially business outlets. They emphasised instead their health professional skills, which included hosting a syringe-supply scheme. According to the Pharmacy Council: "... the profession, in adopting an active role, will provide a further demonstration of the front-line position that pharmacy has in the provision of primary healthcare" (Shaw, 1988: 1). Although pharmacy was organised into private businesses where managers made tactical commercial decisions, it was also a profession, where strategic decisions were made collegially. Sufficient numbers of pharmacists needed to agree that involvement in the NEP was indeed their best strategy, both as businesses and as a profession. However, the pharmacy leadership did not first consult their grass-roots membership over this decision. This tactic of constraining the available choices added to the significant, though minority opposition, to providing the infrastructure for the NEP.²³⁴

During the process of gaining pharmacist support and thereby enrolling their professional and commercial infrastructure, the general concept of syringe supply was replaced by a more precise

231. The user-pays aspects had been decided sometime between July 1985 and November 1986.

232. See McLeod (1988), Booth (1988), Nimmo (1995a, 1995b, 1995c). Pragmatism absorbed professionalism. The more general absorbed the more specialised. This absorption metaphor appears the opposite of crystallisation metaphors, where 'the more structural' fixes 'the more general'.

233. For a review of neo-liberal changes and resistance see Boraman (2004).

234. This opposition appeared stronger in the southern regions. If not defused, it could have grown and deprived significant areas in the south of outlets. However, it seems unlikely that the degree of opposition could have led to a blanket prohibition on any pharmacist volunteering for the prospective NEP, since that also would have been constraining a pharmacist's individual choice as a small business owner and a professional exercising discretionary judgement.

concept of exchanging syringes combined with user-pays. Syringe exchange was demanded by health professionals and police to safeguard health in public-private places, such as the domestic environments of IDU which police searched at times, and in the fully public environments that were also jeopardised by discarded syringes. Exchanging syringes helped frame the pharmacist involvement as a public health activity, rather than as facilitating drug use, which merely supplying syringes might seem. The NEP became more solid when the pilot-tested, semi-commercial, pharmacy, user-pays practice was reconfigured as an exchange model. This model was presented as strategic and logical, whereas the community and counselling components were left tactically ambiguous. This model and procedure seemed rigorously health oriented, yet also pragmatic, while being acceptable to IDU customers in a way that reduced the significance of their illicit habits, yet was necessitated by the very same habits.

The NEP planners knew that IDU did not perceive pharmacists as a major threat (Department of Health, 1987f: 6), which seemed to increase the chances of success. The expertise of the professional pharmacists also offered consistent standards, work, and evaluation all within a national scope of co-ordination. The pharmacists' public image as self-sacrificing health professionals was reinforced by their involvement in the NEP, and the value of pharmacists as independent health practices was reinforced at the level of health policy. The pharmacists' customers, now including IDU, followed in this stream. It was not until pharmacists, as a professional body, agreed to supply the infrastructure that the concept of a 'Needle Exchange Programme' emerged as an interplay between a solid, shaped boundary outline and a core. Nevertheless, much that later emerged was then amorphous, since the support from pharmacists and IDU could clearly not be assumed, nor directed from outside in any reliable way.

3 Pharmacists both support and constrain the NEP

Oppositions and uncertainties rapidly emerged in response to the initial plan for the NEP. The pharmacy profession had supported the NEP, but only in an opt-in system (Donaghue, 2002, pers. com.). In the first month some individual practices left and others joined, since pharmacists only participated to the degree that the NEP fitted in with their existing operations and commercial logics.²³⁵ Their resistance to any official direction of their commercial and professional activities created openings for alternative service providers and for competing expert advice from IDU groups.

The earliest estimated date for the NEP to begin operating had been May, 1987. This deadline was

235. One pharmacist stated: "I was all for the needle exchange scheme - until I received its checklist and questionnaire [sic]. This was supposed to be a simple scheme. I do not wish to participate now... If you don't feel our ethics and training is [sic] sufficient to insure our integrity, you shouldn't be involving us in the scheme (Booth, 1988).

pushed back to January 1988 due to underestimating the degree of negotiation required to settle commercial uncertainties that emerged over supply. The early tendering had produced only one likely supplier, which led to an effective monopoly by Salmond Smith Biolab. Then, after arrangements had been settled but no shipment had been dispatched, the IV League warned that the Australian syringes on order were too small for the particular drugs injected in New Zealand.²³⁶ The resulting delay unravelled a degree of the pharmacists' enrolment, (Ashby, 1988: 18, 1987) while magnifying the uncertainties of the planning. Nevertheless, this delay taught Department officials to minimise such risks by consulting with IDU, prior to decisionmaking, since IDU were the most committed and expert stake-holders. By contrast, the commercial supplier 'stakeholder'²³⁷ avoided commitment unless sufficient short-term profits, or long-term monopoly control, offered compelling commercial incentives.

The NEP planners considered that frequent shifts in the buying-in costs of syringes would render efficient administration of the NEP impossible (Baker, 1988b). But the syringe suppliers insisted on negotiating for no more than six month blocs, to reduce their vulnerability to not being able to pass on increases in their own costs. Their insistence equated to lengthening the time taken in negotiations with the NEP planners, causing further delays in the starting date, with the planning officials being primarily accountable for such delays. These differentials in incentives induced the NEP planners to try to stabilise such market uncertainties, but the only mechanism, apart from regulations that were unwelcome in the neo-liberal political climate, was to allow increases in profit to insulate the syringe importers from commercial risk. This seems why the syringe costs actually increased for several years.²³⁸

The increased cost loadings impacted primarily on IDU because of the user-pays mechanism, combined with the absence of IDU representatives in the negotiations. These commercial arrangements for fixing costs proceeded amicably until the negotiators were advised by Commerce officials that their proposed arrangements would breach the price-fixing prohibitions of the 1986 Commerce Act (New Zealand Government, 1986). Their legal advice warned that applying for an exemption could be long and uncertain, since the Commerce Commission was an independent body (Department of Health, 1987c; Donaldson, 1987). The NEP planners needed to consult with Health, Commerce, and legal officials before gaining an effective exemption,²³⁹ adding to the

236. Many drugs injected in New Zealand have been bulky due to being home prepared from poppy latex, or from being only partially separated from fillers in pharmaceutical pills, or from being a syrup such as methadone. (See Appendix 5) Because the syringes were required to be larger than initially planned, the return containers (see Appendix 6) also needed to be larger, which meant the Australian design could not be used. The arrangements for redesigning, purchasing, and the logistics of transport for syringes and containers were renegotiated. See Caygill (1988a), Kerse (1988c). The type of drugs is also the reason why the supply of high quality filters (see Appendix 4) has been so important for safeguarding the long-term health of IDU.

237. A contentious term since suppliers had no solid, committed stake in a relatively tiny market.

238. After 1989, ADIO, the peer exchange in Auckland, developed a strategy of breaking the monopoly on syringe supply (Nimmo, 2004. Pers. Com). The other peer groups followed ADIO's lead, which forced officials to accept the peer groups selling a range of different types of syringes, not necessarily in the approved safety canister.

delays before the NEP started operating.

The NEP accumulated a growing number of stake-holders as its planners attempted to 'fix' its activities into a stable, predictable, accountable structure. The NEP acted as both fixed and comprehensive. It seemed fixed when it reassured uncertain stakeholders by containing its growing linkages and costs within a changeable, semi-marketplace. Yet the need to be comprehensive required adaptability, which opposed being strongly fixed. This conflict increased when commercial uncertainties and shifting profit margins altered motivations. Moreover, there were no reliable data on the distribution and motivations of IDU (Walzl (1994: 45); Baker (1988b: 73). Importers, like pharmacists, dealt with syringes in an oddly constrained, semi-commercial and semi-market environment, since officials:

would prefer a single cost to apply throughout the country. To calculate this we suggest that you average out your quoted freight rates and weight these according to the population in each area. ... the department has not arranged supply of these packs on a tender basis. ... [nor is] in a position to guarantee that any one company will be the sole supplier of the packs.
(Baker, 1988b)

The Department held the most influence, interests, and control in this network configuration. The Department chose to renounce direct control and rely instead on commercial agents, complying with the neo-liberal policy environments and ideologies of that time. Yet rather than relying on open market forces, the Department proposed a form of regulated market, while reserving the capability to act as a governance agency by altering regulations and telling the supplier how to calculate costings that were required to meet the Department's expectations. These regulations ensured both rigidity and flexibility. The rigidity simplified client acceptability and management, while the flexibility facilitated adjustments to an unknown future market. The regulatory approach also facilitated a competitive environment where the service providers could be potentially replaced. There were no hands-on direct monitoring and directives which could lock-in particular organisational forms, skill-sets, or specific contract outputs and thereby reduce competition. Nonetheless, price-fixing through central directives via non-market mechanisms, together with regulations that prohibited the casual entry of private entrepreneurs, established a monopolistic framework, within which a system of multiple service agencies developed.

The pharmacists' professional bodies, in contrast to the syringe importer, insisted that the Gazetted supply price to IDU and the buying in costs from the importer should be absolutely fixed. This was to retain their profit margin which was described as an advisory fee. For pharmacists, unlike importers, fixed prices removed many commercial risks while reducing their professional and managerial problems of price-setting. Without control of all costs, the fixing of prices to IDU clients entailed increased financial hazards through potential increases in labour costs or importer profit margins.²⁴⁰ The logics that supported fixed prices also supported government subsidies in

239. As far as I can ascertain, IDU were not consulted as customers over the terms of this exemption.

areas where fixed prices did not cover the financial risk. These risky areas included the costs of disposing of returned syringes, form-filling, and the obligatory ‘counselling’ interactions with clients demanded by the AIDS Advisory Committee.

The pharmacists’ leaders reported their members’ dismay with increasingly detailed provisions for monitoring and regulation as described in the Management Plan (Coville, 1987). Yet the plan needed to be comprehensive and rigid to voluntarily enrol the people and agencies that wished to avoid the potential professional, managerial and ‘moral’ problems of being associated with IDU.²⁴¹ However, such rigidity created problems for those who became subject to the plan. This rigidity, together with other factors such as increased costs and the shortage of staff qualified in counselling, led the pharmacists as a body to reject any involvement in the counselling component of the proposed programme. Pharmacists had already chosen a career, and it was in pharmacy, not in counselling. The pharmacists continued to consult with other stakeholders over the various aspects of syringe exchange, while making it clear that they totally approved of counselling, provided that they themselves were not inconvenienced by it in any way.²⁴²

The design of the pharmacy programme had offset the voluntary participation by pharmacists against the removal of control by pharmacists over the professional fee component whenever syringe prices were being set. The controls over syringe prices were vested in the Regulations, as monitored and enforced by the Department, where both the regulations and the Department were relatively fixed and stable entities. Baker had designed the pharmacy input to be consultative rather than negotiative,²⁴³ since genuine negotiation implied that prices might change as an outcome of negotiation.²⁴⁴ Yet if prices and costs changed, the ratio of political accountability to risk would also change, requiring hands-on management or hierarchal system linking implementation to policy making levels. The fixing of costs minimised any need for continuous official supervision. Consultation required the Department to listen to the views of pharmacists, but not to necessarily act on them. Yet since the pharmacies could easily withdraw from the NEP, any long-lasting problems that encouraged their departure would force an official intervention of some sort to maintain the NEP services.

When the NEP Management Plan was released in November 1987, many pharmacists objected to the content and implications of the proposed official monitoring.²⁴⁵ Some considered that by definition, any qualified colleague possessed adequate training and discretion to dispense syringes. Several members of the Pharmacy Council insisted that any pharmacist should be approved to

240. See Coville (1987, 1988: 1), Walzl (1994: 47-48).

241. See Salmond (1987), Dowling (1987b), Caygill (1987a), Hadley (1987).

242. See Hadley (1987). Pharmacists supported counselling, but only provided they were not inconvenienced by it.

243. See Baker (1987a), Coville (1987)

244. This seems because the willingness of negotiating parties to make compromises constitutes the basis of trust required for negotiations to begin and for outcomes to be sustainable.

245. See Patel (1988), Salmond (1988a), Baker (1988a), Millar (1988).

provide a NEP outlet, since being unsuited to selling syringes equated to unsuitability for being a pharmacist. To act otherwise insulted their professional status, which harmed their public reputation and jurisdiction. In being 'the health expert the public saw most frequently', a dangerous precedent seemed set by regulations that implied that their professional capabilities were inadequate. These Council members argued that reducing the participation by pharmacists in decision-making would harm rather than help the NEP. By contrast, one senior, well-established medical professional argued against the proposed pharmacy infrastructure of the NEP because such involvement would detract from the professional image of pharmacists (Spittle, 1987).

The pharmacists had historical reasons to avoid impropriety, particularly to do with illicit drug use. *The Drug Dependency and Drug Abuse in New Zealand Report to the Government* described widespread misuse of medication from:

Considerable laxity ... for the dispensing of prescriptions between medical practitioner and pharmacist ... Prescriptions were written by pharmacists and presented to the medical practitioner who signed them ... the average addict was most likely to be a nurse, a doctor or a kiwi with a cough ... [In 1947] the Director of Public Health Division told his Minister "unless sufficient and competent staff are appointed, I cannot take responsibility for the control of dangerous drugs (narcotics)" (1970, as cited in Lee, 1987: 115).

Two years later, amended legislation reduced the maximum number of oral doses of heroin contained in a single prescription to sixteen. During 1947 official records show that 319 kilos of opium, seven kilos of heroin and 12 of morphine had been imported and presumably consumed. However, three quarters of the opium tincture, half of the powdered opium and one quarter of the cocaine went 'missing' from the records of prescriptions and accounts of pharmacies (Lee, 1987: 115). This background informs a better understanding of the attitudes of the pharmacists, doctors, and Department officials, especially the regional 'watchdogs' such as the District Advisory Pharmacists and Medical Officers of Health. This history lay within the living memory of the older pharmacists, despite never being mentioned by professionals or officials. This history and that silence together inform us of the character of health research, where 'black boxes' of various shapes are best not taken at face value.

Another professional concern entangled accounts of legitimacy with those of ritualism. In late-1987 the National Society on Alcoholism and Drug Dependence promoted a campaign of disinformation, in which they claimed that IDU shared syringes for ritual reasons. This false information promoted their argument that harm reduction could not be effective because it relied on control and rationality, whereas sharing syringes supposedly involved an irrational, uncontrolled adherence to rituals. Nevertheless, in April 1987, a review of IDU attending a Wellington methadone clinic had found that IDU had decreased their sharing and increased their sterilising of syringes despite their

lack of legal supplies and seemingly due to influences from within their own networks rather than to direction from outsiders. These data countered the attribution of ritual syringe sharing (Lee, 1987: 114), which itself seemed influenced by many drug treatment specialists wanting to protect their professional jurisdiction and theory by magnifying the stigma of ‘their’ IDU clients.

Parliament accepted the NEP legislation changes as initially drafted, then sent the Amendment Bill to the Social Services Select Committee in June 1987 (Baker, 1987a: 4). This process involved stages of ‘translation’ and ‘enrolment’, as in Latour’s descriptions of actants becoming enrolled into alliances (1999: 103-104) which become mobilised in projects. Latour describes enrolment as following from processes of translation (1999: 194-195), involving:

all the displacements through other actors whose mediation is indispensable for any action to occur. In place of a rigid opposition between context and content, chains of translation refer to the work through which actors modify, displace, and translate their various and contradictory interests. (Latour, 1999c: 311)

Translation combines storied information, documented accounts, and distributions of motivations. The stages of the NEP enrolment involved a draft Management Plan, then consultation and persuasion, to prepare for the initial infrastructural consolidation. Yet the shaping of the Management Plan and subsequent operations depended upon the phases and delays of the legislative package. This package itself changed in form as it gained and lost clauses, then split into two Acts, a Misuse of Drugs Act Amendment and a Health Act Amendment. These delays offered the NEP’s ‘opponents’ time to unravel the enrolments and counter the translations. The opposition, as Latour helps us to understand, was constituted from a range of tactics of displacement and replacement, mediated by actors, actants and an obligatory passage point that could not be avoided. Whereas some actors wanted to halt the NEP, these were mostly not in a position where their participation was obligatory. For some others, whose participation was obligatory, delay was desired to give more opportunity to reconfigure the Bills. They attempted to sap the momentum, and divert the trajectories of the NEP as it consolidated from a virtual concept into an actual social entity. Proponents of the NEP ‘translated’ around the built-in ambiguities of the NEP’s conceptual hybridity. Clauses of promises and evasions, laid on the conceptual table as quasi-objects, rubbed virtual shoulders familiarly with the objective slickness of the sterile syringes that told their own increasingly professional story of capabilities. IDU were mostly an invisible presence, always mobile, seldom tabled. Similarly, HIV was only seen and talked to in semi-human form, though read through biomedical and epidemiological and social science documents. This game had logics of play, cheating, and timetables. Once the details of the *NEP Management Plan* and legislation were publicly specified, the opportunities for alliance-building to oppose or reshape the categories in play also increased, despite the initial support for its general concept.

Regardless of the need for speed from the perspectives of the NEP’s planners, it was convenient for

the *NEP Management Plan* to remain unfixed until well into the period of the Select Committee's deliberations.²⁴⁶ The Bill thereby enrolled support while neutralising or evading opposition. During these stages its shape changed as its greater support meant that it became less or more dependent on its fitting into the programmes of particular actors and actants. The shape also changed as the Bill became vulnerable, thereby needing deflection shields or armouring against opposition. As the proposal solidified into a Bill it had become sheltered, depositing 'negotiation layers' of parliamentary bipartisan committees in uncertain proximity to committees of health professionals and MPs. The Bill was also screened by other mechanisms of consultation with a more mobile character and uncertain scope, such as the IV League. These layers, agencies, and increasing documentation, in combination, presented an image of consultation and consensus that helped propel the legislation through the commercial, political, and professional passage points. Yet such an historical story of a forceful flow is countered by a better story of negotiated stages, where the temporal dynamics mesh parsimoniously with the character of strong antagonisms being linked protestingly into a legislative mechanism.

Even in a scenario where the possession of syringes became legal, the New Zealand Medical Association (NZMA) raised objections to pharmacists or medical professionals supplying objects, such as syringes, to be used in illicit activities. The NZMA exercised an authority to speak not only for its own actual membership, but also for the minority of pharmacists who opposed the two pharmacy professional bodies. Warren Lindberg, the Director of the NZAF, publicly condemned the Medical Association as ill-informed and showing "ignorance, fear and Victorian morality" Lindberg (1987, as cited in Wright, 1989). At the time, the NZMA claimed to represent 4,700 medical practitioners, which would have included about 72% of the profession in New Zealand. Nevertheless, there is no record that the NZMA had actually polled its own members beyond those directly in contact with its leadership at the time (Baird, 1987; McLaughlin, 1987: 30). Nor did the NZMA record the number or degree of support or opposition of those members that were polled.²⁴⁷

Other medical professionals vigorously criticised even the AIDS Advisory Committee's delicate stances. One lamenting doctor advised the Department:

No doubt this is a recommendation from the AIDS Advisory Council? Some of the decisions and recommendations of the latter have caused some concern to many of us within the medical profession. ... Why not forget the question of making free needles and syringes available to drug addicts, with all the problems that will generate ... many believe [this] would be an appalling decision with horrendous consequences. (Bailey, 1987: 1)

246. The timing of the process was influenced by skill in committee work. The movement of legislation through the Social Services Select Committee relied initially on bipartisan support. Later, when difficulties and opposition emerged, the timing of the progress of the legislation depended more upon the Labour dominance of the committee membership. Other committees were useful for enrolling parliamentary support and for reassuring the public. When difficulties emerged they did not meet, according to comments in Hansard by National MP, Don McKinnon (Hansard, 1987). After the legislation passed they vanished, having no further purpose. See Luke (2002).

247. The unaccountable authority seen exerted by the NZAF, in a context of moral agendas, clearly requires ongoing study. From an anarcho-sociological perspective, the NZMA was assuming the directive powers and moral authority of a 'medical state' as an anachronistic state of domination, irrationality, and ritual within a modern globalised state.

Another emphasised that the requirements for the surveillance of the epidemiological and addiction aspects would necessitate a high degree of bureaucratic control. He argued that the NEP should not be supported if IDU numbers continued to increase, and implied that the increases in Temgesic injecting between 1983 and 1987 were driven by the increased availability of illicit syringes.²⁴⁸ Yet he offered no alternative to the NEP if IDU numbers continued to increase (Malpress, 1987). Medical bodies also opposed the NEP service fees for medical practitioners being fixed. Like the pharmacists, these bodies resisted any external controls over their professional competency to practice, and objected to the time involved in record-keeping.

The Society of Medical Officers of Health only supported the NEP with the greatest reluctance. This Society argued for increasing funding in the addiction treatment area, but not with the intent of subsidising the price of syringes, or facilitating the NEP, or extending its capabilities. Instead, the Medical Officers of Health wished to minimise the number of pharmacy outlets, while increasing the funding and numbers of drug treatment clinics (Flight, 1987). They opposed the treatment and prescribing by GPs for people with substance dependency problems, since "more problems are created than solved" (Flight, 1987). However, they considered that drug clinics with strict protocols tied into 'self-help, 'higher faith' programmes that had a greater and proven record of success. These Medical Officers did not cite their criteria for drug treatment being successful, nor their sources of information.²⁴⁹

The NEP was supported by the Royal New Zealand College of General Practitioners (1988), the Royal Australasian College of Physicians (Stace, 1987), by pharmacy representatives, and by nursing bodies. Nevertheless, these bodies and the AIDS Advisory Committee did not represent 'the medical profession' as a whole. The AIDS Advisory Committee was a particularly composite actant, with members selected by the Minister on advice from Department officials. Some health professional bodies deeply disliked the NEP, whereas others offered uneasy yet clear support. No dominant profession came to claim jurisdiction and accept accountability for the presence or absence of the scheme. This opened the territory to the strongly motivated profession of pharmacy, while encouraging lay input from IDU communities.

The back-stepping by medical professionals strengthened the pharmacists' negotiating hand by removing any existing alternative professional infrastructure.²⁵⁰ The logics and character of medical professionalism, at that time, positioned pharmacists with a uniquely desirable product in a sellers

248. Intriguingly, given his Medical Officer of Health accountabilities, Malpress did not explore the possibility of Temgesic medication being over-prescribed by GPs, similarly to the 1940s problems of missing opiate imports described previously.

249. This situation and stance seems related to Davenport-Hines' description of drug treatment history in the UK. Davenport-Hines describes a state agency backed, professional takeover by an abstinence-oriented, self-interested school of clinical psychologists and psychiatrists (2004: 365-374).

250. Social work agencies, either public or private, might have provided an alternative model. However, social work was at the time a disorganised occupation, struggling against the imposition of both bureaucratic and market models. See Munford & Nash (1994: 11), Beddoe & Randal (1994: 26-29), Nash (1994: 68-76).

market. The pharmacy character and logics oriented the NEP towards persuading lay customers into public health attitudes and product usage, rather than being merely concerned to maintain compliance by patients during 'treatments'. The AIDS Advisory Committee was expected, in being the Minister's advisory body, to publicly support the Minister's and the Department officials' pragmatic rationale for rejecting a clinic-based NEP. The Committee's sole alternative stance was to offer convincing evidence against the proposals. This was difficult before the NEP began producing evidence. It was also unlikely since the Committee could not have easily retained its resourcing and influence after publicly embarrassing the Minister. Moreover, there were others that wanted access to the Minister's ear.

Nonetheless, the AIDS Advisory Committee did insist that the NEP be based on obligatory counselling at the point-of-sale, as discussed in the following chapter. The Committee also insisted on the obligatory exchange of old syringes for new, disagreeing with the Department head officials and the Minister's NEP planning team (Baker, 2004 pers. com.). The NEP planners instead prioritised a cost-effective, workable exchange scheme, with counselling only a secondary goal to be implemented later. As its design consolidated, the NEP came to incorporate a returned syringe component. But this exchange aspect was achieved through incentives rather than enforcement, while proposals and demands for obligatory point-of-sale counselling were also rejected.

At the stage when counselling became clearly a secondary goal, the AIDS Advisory Committee began making formal statements of opposition to the implementation aspects of the NEP, while supporting the general principle that an NEP of the 'proper, medically approved' type should exist. Their arguments began to be heard and used by opponents of the NEP, for instance in the NZMA submission opposing the NEP legislation (Baird, 1987), and in speeches from National Party politicians on the Opposition Benches who had come to oppose how the NEP had developed despite being committed to bi-partisan support. These politicians demanded a sunset clause on the NEP legislation on the third reading of the Bill (Hansard, 1987), but the Labour Government dominated the Select Committee and had a clear parliamentary majority.²⁵¹ From an actor-network perspective, the syringes also voted, and they carried the play.

4 What was all the fuss about?

In this story, the proponents of the needle exchange programme 'inherited' policy turf from the gay-focused HIV/AIDS community organisers. These community organisers initially established the positioning of expertise, along with principles of policy and programmes, which later contributed

251. According to *The Elective Dictatorship in New Zealand* (Mulgan, 1992), a system whereby the executive branch of government wielded 'unbridled power' (Palmer, 1987; Mulgan; 2004) was only beginning to shift to a system where select committees could act to delay or check executive dominance.

to the shaping of the NEP. I suggest that without this prior activity, different syringe supply outcomes would have eventuated. However, the connections between the gay and IDU organising did not automatically follow, despite similar sustaining logics of a requirement for trusting participation, by an untrusting and untrusted marginalised communities. Nor did such organising suddenly emerge in the form of new global realisations. Instead, we see the environment shifting configurationally, in stages, where each stage seemed workable, at least for a while, yet only those arrangements that became workable within their wider systemic resources and constraints could actualise into a stable programme. This environment included technological devices, such as syringes, along with logics of political calculations, with codified procedures of bureaucracies, with medical collegiality, with markets, with secret criminal networks, and with professional knowledge activities. The NEP organising became activated by HIV, and by HIV-positive people in combination with the stability of long-lasting objects and institutionalised arrangements.

Policy responses to AIDS had been initially avoided by New Zealand and allied governments,²⁵² yet increasing scientific knowledge reshaped the political environments by shifting the boundaries of the known, the necessary, and the expectable. Social science research began to show how viruses were differently understood, widely transported, and trustingly transmitted. Epidemiological and physiological research suggested that the illness which had been defined as a 'gay plague' could spread into general populations. 'It' could spread by means of a greater number of routes than had been visualised across boundaries of stigma, prejudice, law, and health policy. A shift in professional boundaries began to be strategised, as social-material reorganising followed the social dangers of material connections across institutional boundaries. As shift followed shift, actors and actant objects became redefined and re-problematised in processes of enrolment and translation. The key to this process was the 'holy grail' of drug treatment professionals, that is, the reliable, self-sustaining change in motivation of IDU. Paradoxically, drug treatment professionals were not only distrusted by IDU, but also could not take part in the NEP because of their own treatment ideology that demanded obligatory abstinence.

Politicians could challenge the existing legislation and access funds, yet their attitude to health professionals was ambivalent. Cabinet needed to retain public confidence in the budgeting and effectiveness of the health system, particularly the HIV/AIDS policy. Cabinet had decided to increase political control over health expenditure by constraining or replacing professional medical leadership with market-oriented management directives and evaluations. For example, the colloquially termed Gibbs Report²⁵³ promoted a quasi-market approach to hospital policy. Yet to

252. New Zealand's government, and perhaps its citizens, are members of an English speaking military alliance. This alliance is held together not by military cooperation, necessarily, but by cooperating in information gathering through a global network of electronic interception sites. One term for this alliance is Echelon, and one of the New Zealand bases is in Waihopai (Hager, 1996, 1995). The members of this alliance include Australia, Canada, the UK, and the United States of America. The existence of this alliance facilitates transfers of technology and policy between these societies.

maintain public confidence, professional expertise and authority over HIV/AIDS needed to be presented in a high profile, reassuring way. The requirement to actually constrain, while simultaneously promoting professional leadership, partly explains how health expertise became packaged in small, controllable, advisory groups, while through the same policy environment, the delivery of health services became offered to less powerful professions and community groups.

The health experts who specialised in contagious diseases were drawn into informal dialogue with medically trained Department of Health officials. This network imported overseas models, adapted them to New Zealand's political, cultural, and financial environments, and consolidated them into packaged processes of expert advice. When a change of government to Labour in 1984 delivered an activist Cabinet and Minister of Health, a circle of medical professionals and health officials had already begun to established an informal crisis advice and management team. However, a more formal and focused alliance of medical treatment, public health, and political expertise then bridged the well-maintained lines of division without (overly) destabilising the wider, historically rooted alliances which maintained such differentials. The Minister developed contentious relations with GPs and hospital-based medical specialists, yet maintained mutually respectful relations with less dominant professionals, such as pharmacists, who wanted greater legislative protections.

The twin goals and methods of the NEP developed out of an initial categorisation of the primary and secondary types of health delivery. The initial application of these types of health delivery to IDU was normative rather than pragmatic. The initial concepts involved a goal of prescribed individual abstinence, rather than a goal of implementing prevention programmes through the voluntary compliance by IDU. But given that gay men refused to stop having sex,²⁵⁴ despite fears and incentives for abstinence, IDU seemed even less likely to stop injecting.²⁵⁵ The gay community models of 'controlled practices' and of 'policy participation' had become the general policy and supportable as 'best practice'. Refocusing on the social aspects displaced a biomedical fixation on individual treatments by instead prioritising public health, syringes, and safer material environments for illicit practices.

The shifts between the initial concepts of primary and secondary priorities relocated the concept of safer material environments, along with social network environments, further within the boundaries of official health policy frameworks. Such models threatened most of the existing medical jurisdictions, but privileged the public health and pharmacy jurisdictions. The NEP planners, despite the urgency, ensured that no hasty decisions were made until the costs and effectiveness of

253. *Unshackling the hospitals : report of the Hospital and Related Services Taskforce* (Gibbs, 1988)

254. The term 'having sex' is clearly misleading. People 'do' sex because it is an activity, which is 'done'. What they expect, experience, or have at various stages, is well worth study, perhaps using a participant observation methodology, but as a short, parsimonious indicator of an activity, the term 'having sex' will clearly not do.

255. Because a prescription was being enforced, an ideological underpinning has seemed apparent, in that adherence to an ideology has been a further goal, one which excused or made up for the record of failure of the supposed primary goal of health. It does not seem unusual in a 'messy reality' for different goals to stack and intersect.

both the goals and the implementation of alternative strategies had been considered by key stakeholders. As the organisational responses to HIV/AIDS became better established as an integrated strategy, the problems and opportunities of preventing HIV transmission in IDU shifted to include more of the public health issues that had been labelled 'secondary' in 1984.

The conflicts over goals continued to influence the preferred means of implementing the shifting outlines of the tentative NEP. Yet at the same time, conflicts over implementation influenced the setting of the formal goals of the NEP. The goal of abstinence had already informed the professional methods used in existing treatment clinics. Yet the individual IDU who stopped injecting, and were no longer considered an HIV risk, carried no further influence in IDU networks. This 'drop-out effect' blocked individual motivation changes from propagating through the IDU networks (Meech, 1987e). Accordingly, the IDU social links and trust became increasingly acknowledged by Department officials as a resource, following the pragmatic logic that these aspects could not be controlled from outside. The existing model of the NZAF and its work on safe sex offered a conceptual tool, not of IDU controlling syringe outlets, but of IDU outreach being introduced as a strategy alongside and dependent upon pharmacy-based needle exchange outlets (Lange, 1987).

By 1987, priorities had shifted towards following and building on the existing pharmacy and IDU practices through pragmatic, minimalist arrangements. Unlike the enforcement of abstinence, the supply of syringes could be cheaply implemented. The twin goals of incremental motivation change and rapid environment safety came to constitute the NEP's core activity. Sterile syringe supply, along with an incentive for returning used syringes, contributed to greater protection from the spread of HIV/AIDS and other blood-borne viruses amongst IDU and the wider community. Motivation change was provided through educational reading material that treated IDU as already motivated and competent, merely lacking in resources. Although some interpreted this arrangement as ethically negligent, in not providing obligatory professional counselling 'treatment'²⁵⁶, it better fitted the IV League's expert knowledge about drug use. The arrangement also facilitated policy change, because different aspects could be emphasised depending on context. The most significant shaping of this model involved the conflicts and alliances around the boundaries of health professionalism. These boundaries were connected to and realigned by the Department of Health officials and the NEP planners who promoted the legislation changes, who minimised or contained managerial and hierarchical influences, and who designed the regulations. Such processes inscribed network shapes deeply into the NEP arrangements while adding the NEP to the existing health networks.

256. From a professional ethical perspective encouraging the use and payment for professional services is a public service good. The lack of such encouragement invites competition from other professions, which is not so good since they cannot be considered to be more expert or useful in one's own professional jurisdiction.

The control of the AIDS Advisory Committee by medical professionals seriously threatened the rapid introduction and effectiveness of the NEP.²⁵⁷ If the 'harm reduction alliance' had turned out to be weaker than the 'professional medical alliance', the NEP's capabilities would have suffered. To counteract such potential opposition, and to begin constructing supportive institutional environments for a difficult project, required what actor-network researchers have termed stages of 'translation'. Such stages describe how successive engagements, linkings, and co-ordinated activity can influence how a 'solid narrative' of causes and consequences becomes grouped and framed in motivational accounts.

Policy changes, such as adaptations of syringe supply models from overseas, can be explained by tracing the sites and movements of network interactivity alongside those of key actors. Each step of technology, geography, law, infrastructure, and expertise was simultaneously locally embedded, while also an opportunity for changing the local configurations of institutional and organisational linkages. The term 'needle exchange' travelled, but the workings and consequent meanings were locally assembled from what lay at hand.

The exchange of new for used syringes was not obligated by regulation, as in some overseas models. The NEP has seemed better described as a syringe supply programme, with the return of syringes being encouraged by a price discount. Conventional anthropological concepts of gifting or other exchanges (Titmuss, 1997; Appadurai, 1986: 3-5, 11-13, 26-28) have seemed less relevant in the commercial NEP environment of user-pays in a mass, highly regulated market.

The 'exchanges' that constitute the NEP have been similar but different from 'taking', 'getting', 'gift', and 'sale'. The form of these exchanges could be directly and comprehensively 'measured' as the relative movements of mobile forms, such as syringes and health pamphlets. This analytical approach is based on Latour's²⁵⁸ concept of 'immutable mobiles'. It also demonstrates how: "the customary logics of small communities are intimately tied to larger regimes of value defined by large-scale polities" (Appadurai, 1986: 30).

The customary logics of 'exchange' increasingly emerged as not only constituted from commodities, sites, and processes, but also as alterations in larger-scale meanings and structural spaces, such as of legislation, policy, and institutional boundaries. These connected the 'gift' of health protection against an unknown likelihood of infection to a known 'value of distrust' needed everyday by IDU to survive against law enforcement activity. In an earlier example of thinking

257. Dr. Baker, who co-ordinated the NEP developments, indicates that significant effort went into strategically countering the AIDS Advisory Committee proposals that would have delayed the scheme (Baker, 2002 pers. com.). Proposals by members of Parliament that would have placed a sunset clause on the NEP cited the criticisms voiced by the AIDS Advisory Committee (Hansard 1987).

258. According to Gorman (2001), who supports Latour's project, Latour's story of immutable and combinable mobiles (1987: 226-227) was not based on accurately detailed historical information, but nonetheless captures the significance of the historical trail of events, as well as working as a useful model in any event.

along such lines, Simmel argued that in terms of relations between subjective values and objects: “we call these objects valuable that resist our desire to possess them” (1990: 67), yet also that: “the difficulty of acquisition, the sacrifice offered in exchange, is the unique constitutive element of value, of which scarcity is only the external manifestation, its objectification in the form of quantity” (Simmel, 1990: 100). In a needle exchange context, from professional perspectives, sacrifices had been made in the process of promoting an essential type of health care value.

In this second cycle centred on pharmacies and the pharmacy profession, patterns of autonomy from professionals, and alliances of convenience with officials and politicians, were similar to the previous cycle based on gay community support groups and an expert medical advisory committee. Such similarity is partially explained through 'inheritance', as the more durable aspects of the first cycle are maintained by the processes of that cycle, and accordingly continue to influence events either directly or path-dependently. If the gay community organising activity had not successfully preceded the IDU-oriented developments, the concepts of communities and participation, as contrasted with enforcement and segregation, would have developed differently in their ratio and configuration. The comparative case of HCV²⁵⁹ illustrates the significance of this timing by being primarily blood-borne rather than sexually transmitted. HCV created a situation equivalent to there having been no previous gay cycle of policy development.

Other explanations for similarities are found in the wider network environments, where certain aspects and factors that previously intersected and overlapped, did so again, in combinations and consequences that if not identical to previous occasions, were similar enough to produce similar outcomes. Once again, professional, political, bureaucratic, and IDU representatives pursued interests and formed alliances within an overall agreement on an integrated strategic response to HIV/AIDS. Moreover, some of these actors, objects, and agencies were directly involved in the first cycle and transmitted their experience. Lines of institutional connection and division were reinforced, weakened, and repositioned as programmes developed through their implementation and evaluation in practice.²⁶⁰

Pharmacists became enrolled because they and IDU trusted each other more than medical professionals, and IDU trusted each other, and their existing infrastructure could be rapidly and cheaply added to. However, since the pharmacy profession controlled drugs which could be diverted to illicit purposes, pharmacists could not participate in illicit activities. Nor could

259. HCV was first raised by the IV League as an IDU problem in 1986, yet a decade of government unconcern over HCV transmission, and studied inaction over carrying out epidemiological surveys, followed the introduction of biomedical tests in 1990 (Nimmo, 1995a; Kemp, 1996). Studies from the early 1990s, for instance Woodfield et al. (1993), have outlined a path-dependent progress of opportunities not taken. The difference is lethally shocking, illustrating as a counter-history some likely outcomes if HIV had only been blood-borne, and not also sexually transmitted.

260. This was even more apparent later when differences between pharmacists, officials, and treatment professionals formed a context for NEP logics extending from stopping transmission, in a pharmacy mode, to also finding out how active IDU networks connected drugs, syringes, and bodies, in a professional research mode.

pharmacists blur their boundaries with IDU, for instance in client-centred drug counselling outside of the clinic fiefdoms, since that would invite the harassment of staff and clients by police, or create a need for costly, time-consuming supervision.

The police were enrolled through the epidemiological studies of overseas pilot exchanges that were provided by the medical professionals on the AIDS Advisory Committee. Yet some medical professionals considered that the NEP was more of a problem than a beneficial innovation. The pharmacy-centred cycle was unlike the previous or following cycles, in that the pharmacists and their pharmacies were already professionally organised as an occupation. A small number of pharmacists certainly dispensed illicit syringes, but this grass-roots form of organising became re-configured and legitimised through the legislation changes and the infrastructural framework of the NEP. These changes seemed more about the numbers, percentages, and representativeness of practitioners than any shift in organisational type. In this pharmacy cycle, high professional service capabilities were attained as soon as the legislation and regulations had been passed. Cheap, effective operations and forms of evaluation were consequently established with minimal delay.²⁶¹

Because the pharmacy exchange scheme was prioritised over alternatives, the methods for facilitating changes in IDU motivation were left to develop from a supply and return infrastructure based on stand-alone private businesses, instead of the existing regulatory structures and expectations of conventional drug treatment programmes. Interventions could be further separated from the central government's controls over expenditure by being based on a user-pays infrastructure of exchanging syringes. Nevertheless, interventions based on pharmacies might draw on the existing pharmacy monitoring through Medical Officers of Health and District Advisory Pharmacists. The prospects for some sort of motivation change policy and programme were ambiguous, since the possibilities of implementation were linked to the problems of accounting for funding and evaluating outcomes.

The prospects for providing a motivation change component for the NEP were explored from 1985 to 1988. During this process a 'syringe as object' focus was joined to a 'motivation change' focus. 'Individual protection' was also joined to 'collective environment safety'. This hybridity was a pragmatic response to a need for an HIV/AIDS programme to be workable and substantive across unknown IDU practices, and without excluding useful expertise. This flexibility overcame the objections of medical professionals to syringe supply alone and to a lack of qualified counselling at the point-of-sale. The flexibility also allowed a substantial programme to work around the 'missing actant couple' of there being no cure for HIV/AIDS, nor for being an IDU. As a pseudo-object, the NEP legislatively coupled the empowerment of IDU to the stigmatising of drugs, so that:

legislative control over certain drugs of abuse is enhanced, and on the other hand, legislative

261. Six years later an independent consultant agreed that although the pharmacy based NEP led in many ways to discontinuities and incoherence, it had been essential as an initial step (Walzl, 1994).

initiative is taken to reduce the risk of transmission of AIDS within the drug-using community, and from there to the community at large. (Keall, 1987: 9)

These harm reduction logics side-stepped the dogma of obligatory abstinence, yet did not directly challenge the jobs and institutions which were based on a cultural ideal of prohibiting 'risky' pleasures. As I will describe in the following chapter, a space for IDU to provide peer services emerged from these logics of connecting different elements in a strangely productive, composite environment.

Although Department officials and health professionals accepted that IDU health equated to public health, conceptions of public order, buttressed by psychological and medicinal authority, were also potentially destabilised if IDU were presented as not requiring urgent health treatment, despite being diagnosed as deviant and disordered. The need to maintain public confidence and order needs to be borne in mind as a less overt mutual goal, despite the oppositions observed between officials and professionals when they participated in developing epidemiological logics into a workable harm prevention programme.

Peer-professional shapings

“ an alternate approach to professionalism [is] based on a ‘partnership’ between the professional and the client ... together identifying what the client wants and needs to know. The ‘new professionalism’ discourse constitutes professionals as ‘reflective users of knowledge and experience’ whose central task is to develop an understanding of the client’s perceived needs ... to the negotiated outcome ... this perspective has more to do with the development and use of interpersonal skills than the application of esoteric knowledge [but] does also involve claims to expertise ... and to professional autonomy.”
(*Professionals and practices*. Tully & Mortlock, 1999: 169-170)

What were the needs of the NEP’s IDU clients, as understood by themselves and others? How did the resolution of such issues hinge upon the way in which passage points between recreation, health practice and policy-making were defined as problems? I described in the previous chapter how a cycle of pharmacy-based NEP developments overlaid a cycle of gay community organising. As with gays, the voluntary participation of IDU was desired, leading to forms of community empowerment through legislation changes, health programmes, and representative organisations. However, the participation of IDU was only as a ‘normal population’ of individual pharmacy clients, not as a ‘valid collective identity’, nor as the providers of specialised health services, let alone ‘care’. This potential gap was addressed by a third cycle, during which the previous methods and logics were extended in what I term a ‘peer-professionalising’ development. IDU peers came to be employed in order to complement the exchange of syringes in pharmacies and to facilitate the proposed professional drug counselling services in clinics. These extensions also increased the opportunities for further workabilities and problematisations in a developing, ramifying area of borderline health activity.

For instance, it seemed inconceivable in 1987 that the pharmacists who were to run the NEP could become sufficiently motivated and resourced to challenge the state agencies which regulated them. However, in 2002 a strike was called by the IDU peer group administrators against the Ministry of Health. The combination of IDU knowledge, peer motivation, and professional types of aspirations to provide adequate health services, directed the NEP into distinctive pharmacy and non-pharmacy courses that nevertheless remaining connected and largely aligned. How did this non-pharmacist, IDU capability come to directly influence the NEP, instead of remaining as a client need and a hands-off advisory function for a primarily pharmacy-based service?

1 Transfiguring policy: between parliament, professionals, and peers

The configuration of actors and actants that participated in directing the NEP’s activities changed after 1987. Some shifted to new positions, and new actors emerged. When David Caygill replaced

Michael Bassett as Minister of Health after the 1987 election, the team of Ministerial appointees that had planned the NEP lost its coherence and tactical position. Nevertheless, the control of this position had become less critical after the legal frameworks shifted according to the previously described amendments to the *Misuse of Drugs Act* and the *Health Act*. Once the NEP became approved as government policy it could be openly defended, administered, and reshaped by Department officials. The obligatory passage point²⁶² of vulnerability to a (rather unlikely) veto, or to the actual proposals for direct Parliamentary oversight through a sunset clause, had been passed (Luke, 2002). The controls over the interpreting and enforcing of the new regulatory code of permissions and penalties had returned to the Minister and the Department.

After the position of Ministerial Aide was disestablished in late 1987, Dr. Baker was contracted by the Department for several months to introduce and co-ordinate the NEP. Those responsibilities then passed to Lorraine Kerse, a full-time Department official.²⁶³ The co-ordination of the NEP had shifted towards the more established Departmental areas, notably the Head Office, the Health Development Units, and the Health Protection Programme (National Council on AIDS, 1988a). By March 1989, Kerse was employed as the NEP co-ordinator in a new Departmental division, once again called the AIDS Taskforce, founded in late-1988 (Fithian, 2005. pers. com.). This transfigured body differed from the two previously described incarnations of that name in being operational as well as advisory. The AIDS TaskForce distributed funds through service provider contracts which it signed-off and monitored. The AIDS TaskForce was also required to somehow arrange for the NEP counselling.

The AIDS Advisory Committee had insisted that point-of-sale counselling be obligatory and integral to the NEP.²⁶⁴ This was due to more than just the personal preferences of its members. The Advisory Committee represented widespread medical opinion which held that an intervening mechanism was required to effect 'IDU motivation change'. For instance, the New Zealand Medical Association opposed the NEP legislation because: "The role of the medical practitioner is to help cure drug users of their habit and not to reinforce it" (Baird, 1987: 2). Many doctors felt that supplying syringes entailed harms and hazards.²⁶⁵ These medical professionals treated counselling as an intervention with at least two goals. One goal was to directly counteract the harms considered inherent in injecting drug use, no matter how 'safe'. The other was to ensure that the programme effectively prevented HIV/AIDS transmission. Achieving this latter goal would justify the more general, symbolic harms considered to be caused by injecting becoming regulated rather than prohibited. Such strategising seems an accepted medical practice of applying professional

262. See Callon (1999, 1991), Callon et al. (1997), Latour (1988: 43).

263. See Moffett (1987c: 5), Baker (2002 pers. com.), Kerse (1987).

264. See Patel (1987), Meech (1987e), Weldon (1987).

265. In this usage, harms actually occur, hazards refer to the possibilities of harm, whereas risk is a precise probability of harm. See Appendix 9.7.

discretionary judgement to the different likelihoods of harm and benefits arising from interventions in the form of treatment.

One story runs as follows. Syringe supply by itself counteracted the stigmatisation of illicit drug use by providing an alternative framework that acted as a 'normalising' health shelter. To justify such perceived hazards of supplying syringes in terms of the medical ethic of 'first do no harm', sufficient numbers of IDU needed to become 'immune' to catching HIV due to their behavioural and motivational changes. Guaranteeing such 'immunity' through a medical treatment approach required that counselling services be imposed by conventional clinics that were controlled by qualified treatment professionals using a bio-psychological theoretical model of disease or disorders.²⁶⁶

Making the counselling obligatory implied that IDU suffered from disorders, and lacked 'normal' capabilities. This stance positioned IDU as diseased, disordered, or non-compliant individuals who needed treatment, rather than standing as public citizens who needed public health systems. This is perhaps why a drug treatment specialist who opposed the NE being based on pharmacies requested: "less blurring of established roles in the public's eye so that pharmacies remained clearly in their current position of promoting health and drug dependence clinics were seen to be continuing to offer treatment" (Spittle, 1987). Any symbolic 'messages' of IDU agency opposed the interest of drug treatment specialists in ensuring that public images of IDU portrayed either public danger or comparative incapability.

The police had only reluctantly come to accept the concept of the NEP, and only after medical specialists on the AIDS Task Force had forwarded supportive epidemiological evidence. The support of the police remained essential, since police harassment of IDU at NEP outlets could destroy the trust needed for any programme to be effective. The AIDS Advisory Committee insisted that the: "preventative and drug control measures by police and customs should not be compromised" (Meech, 1987a).²⁶⁷ This stance was an effective request for police support rather than a demand that the police contribute to health outcomes. These same medical professionals who had been the key to aligning police, political and public support, then insisted that point-of-sale counselling be obligatory. Nonetheless, the NEP was increasing in its 'inertia' as a programme. As it gained safe passage through and away from dangerous policy passage points where the support from police and health professionals had been essential, the NEP gathered institutional 'mass'. It accumulated political and professional investments in a system constituted from increasingly stable connections that returned unique data on IDU and IDU-related health problems.

The accepted best professional practice for modifying the behaviour of addicted patients called for

266. For discussion of drug treatment through abstinence in New Zealand see Jenner (2001), Van Kuppevelt (2000: 25-29, 32-33, 101-103), Collins (1988).

267. This emphasis directly opposed Baker's emphasis that police be excluded from the NEP operations. See Chapter 6.

a combination of controlled drug supply, surveillance, enforcement, and counselling by medical and drug treatment specialists (Ghodse, 1989). Patients could be rejected if they were not fully compliant. This model could conceivably be applied to a tightly regulated NEP that was structured around compelling incentives, but not to a financially constrained system, where drugs such as methadone were not permitted to be made available as incentives, and where compliance was unable to be enforced. Supplying syringes in commercial ways that empowered the IDU customers and did not facilitate counselling treatment would have seemed inadequate and unethical to the drug treatment and medical professionals. This account explains a seemingly irrational insistence by the AIDS Advisory Committee on making a potentially workable programme impossible to run in actuality. Their story was more important for not being actual, but it was a real story that had actual effects.

The international information presented by the AIDS Advisory Committee implied that supplying syringes was in fact harmful, rather than merely wasteful of the resources that could be used elsewhere, for instance by extending abstinence-based programmes. Syringe supply seemed harmful if it was misleadingly presented as a full treatment.²⁶⁸ It seemed harmful if it facilitated any non-professional syringe use,²⁶⁹ and if it removed a disincentive to initiation into recreational injecting. Syringes that were disposed of in public created hazards, along with problems of arranging safer disposal.²⁷⁰ Yet such issues seemed less clear-cut from the pragmatic public health perspectives that centred around ensuring that injecting environments became safer. Until the NEP began operating, there could be no measurement of the levels of participation by IDU and the changes in behaviour required. With no evidence base, the funding of a new counselling infrastructure, or major extensions to existing systems, could not readily be justified. A combination of the demands by the advisory treatment professionals, the refusal by the pharmacists to provide counselling, and the valorisation by the public health officials of the pragmatic, adaptive 'bricolage'²⁷¹ of the resources available to hand, together created a window of opportunity for new participants and activities. This window was opened wider by the NEP Management Plan that was released in December 1987, then wider again by the regulations introduced early in 1988, which presented counselling as a desirable option but not obligatory.

268. Early reports of uncontrolled HIV among IDU in Italy, where syringes were legally accessible without controls, supported such concerns (BMJ, 1987).

269. Doctors had supported syringes being illegal except in medical, scientific, and industrial applications. Those reasons, whether based on health concerns or professional control of specialised technologies, remained valid, despite concerns over HIV/AIDS.

270. Pharmacists insisted that the Department of Health accept accountability for disposal (Shaw, 1988), whereas Australian measures had avoided the problem with a supply policy that did not require returns. Refer 1986 distribution scheme (Wodak, 1987; Baker, 1987a: 72). New South Wales introduced a needle and syringe distribution scheme utilising pharmacies in mid-December, 1986. Dr. Wodak warned Dr. Meech that cost-cutting policies had removed the obligation to dispose of returned syringes, which reduced public and political support for supplying syringes (Wodak, 1987).

271. See Mackenzie (2003), Law (1987), Levi-Strauss (1966: 17-36).

Significant numbers of IDU were considered likely to boycott a scheme based in treatment clinics, whereas such clinics were not prepared to participate directly and publicly in the NEP (Collins, 1988). The Department of Health was a state agency that rationed health expenditure by restraining the autonomy of medical specialists to offer health services that were state-subsidised. The Department officials planning the NEP had incentives to evade demands that entailed increased expenditure, yet also were required to provide counselling in ways that fitted the medical evidence being used by the AIDS Advisory Committee to criticise the NEP. During 1987, a new expert advisory body was proposed to complement or replace the biomedical expertise of the AIDS Advisory Committee. This proposed National Advisory Committee on AIDS was intended to offer social expertise, and to include a wider social range in its membership of community representatives. This Committee was founded after the demise of the Drugs Advisory Committee, and after the formation of the Minister's Committee on Drug Policy (MCDP).

2 What form of counselling, and who would be 'the expert'?

Various conflicts over expertise and authority had continued in several areas of the HIV/AIDS sector.²⁷² One conflict hinged upon who, using which types of expertise and monitoring, would provide counselling services for the NEP. The problem of counselling reintroduced issues of how the framing of the NEP's goals influenced the arranging of methods of implementation. These issues involved boundary disputes among IDU, health professionals, and the public over how to reduce the harms caused by illicit drug use, yet also those harms caused by drug prohibition. Such disputes have continued to influence the interactions between IDU and state agencies. For instance, IDU peers advocated for drug decriminalisation in 1990 (Kemp, 1990). In 2001, a NEP presentation by IDU peers to the Inter-Agency Committee on Drugs²⁷³ showed that a health goal of decriminalising drug use remained on the NEP agenda (Nimmo & Richardson, 2001; Jang, 2001). Such issues strongly motivated a small number of participants who were nonetheless strategically positioned.

In 1987, the Minister of Health had insisted that counselling against drug use would be integral to

272. NACAIDS was referred to by the AAC as "a sort of public relations group" (Dowling, 1987a). Medical experts and social experts argued and manoeuvred over jurisdiction in supplying advice to both marginalised communities and Ministers of Health, and in supplying health services.

273. The IACD is a monitoring group of officials. It ensures that policies and programmes of government agencies are consistent and mutually supportive. The IACD offers recommendations to the MCDP on new policy initiatives. The IACD first met in August, 1998. At issue were the "advisory structures which could perhaps support the National Drug Policy, and in particular how to involve non-governmental organisations (NGOs) and other institutional actors. ... [the Chair of MCDP] indicated that NGOs should be involved when the intersectoral work programme is 'up and running' and then on an 'as appropriate' basis ..." (IACD, 1998). Another issue involved preparing a position for an approaching MCDP meeting in December 1998, where Ministers were to consider and debate the balance between measures for preventing drug-related harm and measures for reducing drug-related harm. The public minutes of MCDP do not include any meetings between August 1998 and June 1999. The published MCDP minutes do not mention this scheduled debate. The following two sets of IACD minutes that might provide explanatory comment are not on the Ministry of Health web-site.

the NEP, but would never be 'imposed' upon clients (Bassett, 1987c).²⁷⁴ The Minister considered IDU to be no different to gays as regarded such counselling needs (Bassett, 1987b). This type of counselling has seemed a form of education, similar to gay HIV/AIDS counselling in not imposing an abstinence ideology. During this period the AIDS Advisory Committee defined counselling as face-to-face education aimed at individual behavioural changes that would induce a social change among IDU towards 'AIDS safe injections' (Meech, 1987e).

Counselling as defined in the initial drafts of the Management Plan during November 1987, involved both drug clinics and community organisations such as the New Zealand AIDS Foundation and the IV League (Baker, 1987b). Several types of counselling had been settled on as appropriate for the NEP. This list included 'real' professional drug counselling as well as a form developed for the NEP, consisting of ad-hoc, 'educational' counselling by peers. A category of 'outreach counselling' was also mentioned, but was presented as quite different from the 'provision of advice' by pharmacists (Salmond, 1988b).

The initial concept of choosing, either as a funder or a drug user, from a list of officially equivalent counselling methods, was replaced in later drafts by an established hierarchy of counselling. This ordered list privileged drug clinic counselling (Baker, 1987c), a type which required ongoing involvement²⁷⁵ and greater commitment by IDU. Nonetheless, this hierarchy was a wish-list, not a directive, and certainly was not enforceable. The NEP planners presented such a counselling context for exchanging syringes as an ideal, to be realised at an indefinite later time. 'Real counselling' was not considered possible in the pharmacies where the NEP needed to be based in order to be viable.

The NEP planners understood that motivation change through counselling was not achievable at pharmacies. Instead, reliance was placed upon a leaflet, to be handed out with syringes, that directed IDU to counselling agencies, since: "The pharmacists see their role as an advisory one, not counselling" (Department of Health, 1987a). Pharmacists did not want to be close to IDU, nor accountable for the time and costs of providing counselling. Nor did the Department planning officials want to provide inducements to pharmacists, since these would need to be large. These officials had consistently preferred the cheapest options for the NEP. However, following the November 1987 election when Labour was returned to government, the new Minister of Health affirmed the need for 'close relationships' between providers of HIV/AIDS prevention education and the representatives of marginalised groups (Caygill, 1987a). Pharmacists could provide syringes, advice, and leaflets, but not close relationships, certainly not counselling, nor any other

274. The lack of on-going commitment to a counselling type of therapeutic relationship, also implied that any costs would be minimal.

275. Since people, drugs, and environments differ, counselling as treatment requires expert diagnosis and evaluation of available resources before any commitment is entered into. See Van Kuppevelt (2000: 34-35, 100-103)

forms of motivation change. Dr. Baker had effectively postponed any resolution of this policy conflict until after the pharmacy-based NEP had begun.²⁷⁶

Professional counselling, outreach counselling, and peer counselling were all listed in the NEP's November Management Plan draft as interventions that might lead to motivation changes among IDU. The outreach services were to be provided by six half-time workers who would augment the preventive education and counselling role of the participating drug treatment clinics. These workers would be based at the major treatment clinics in Auckland, Palmerston North, Wellington, Christchurch, and Dunedin (Baker, 1987c). The description of outreach in the 1987 Management Plan had been borrowed from service planning guidelines for alcohol and drug services. It has seemed more a process of empathising and monitoring, rather than providing resources for any and all who chose to use them. Outreach reached into communities to raise the levels of awareness:

of alcohol and other drug problems, creating a more understanding and supportive environment for people suffering from the effects of alcohol and other drug abuse, identifying persons in need of services, alerting persons and their families to the availability of services, locating needed services, and enabling persons to enter and accept the service delivery system

(Baker, 1987c : 65).

This focus was partly on creating safer environments, with some attention given to the problems of marginalisation and reducing stigma, but mostly on facilitating the delivery of services by professionals. The NEP planners presented outreach and counselling as different needs, to be met by different occupational specialties. Outreach workers were to design activities that supported behavioural change in IDU populations, and would assist in developing new outreach services. The primary role of outreach was to expand the scope of professional counselling services, to augment the preventative education and counselling role of drug treatment clinics, and to direct IDU to counselling services (Poynter, (undated)). Outreach was to complement and facilitate 'proper' professional counselling, not to directly provide motivation changing services in peer-to-peer ways. This formulation of outreach entailed less autonomy, less value placed on tacit knowledge, and less recognition of specialised experience compared with providing professional services. However, the connections and distinctions between such outreach and 'proper' counselling remained ambiguous in the Department of Health reports.

The six half-time workers specified in the Management Plan were to be contracted by and report to officials employed by the Department of Health. The NEP workers were to engage with IDU and attempt to establish NEP outlets at drug treatment clinics, or other appropriate sites. IDU were to be induced by financial offers to attend these 'exchange clinics'. Yet, as with the separate AIDS Advisory Committee proposals, reliance on inducements has seemed an admission that the concept

276. Baker made no attempt to call a workshop, or to invite proposals from prospective providers of counselling services. Instead, Department of Health regional officials were asked to evaluate the counselling services currently provided in their regions.

was fundamentally unworkable and financially unsustainable.²⁷⁷ The actual job description of the outreach workers has seemed closer to the community health, or social work types of education, combined with referrals to professional counselling that might not be available, due to potential constraints on funding.

The workers described in the Management Plan were appropriately professional in being based in the existing centres for providing qualified drug treatment expertise. However, these workers were clearly different from the clinic counsellors in being defined as 'outreach', which implied a more casual level of on-going commitment in their interactions with IDU, compared with a case-management system of client management. Whether these part-time outreach workers were to be drawn from professional, peer, or other backgrounds was left usefully ambiguous.

Professional counselling was presented in the Management Plan as only one, albeit the only fully legitimate and proper one, of a range of counselling types that aimed at motivation change. An initial concept of the validity of outreach by specialised workers, holding ambiguous or no professional qualifications, in non-professional environments outside clinics, has suggested that the NEP's pharmacy outlets were being considered for such a role.

During the same period, the literature²⁷⁸ on forms of non-judgemental, education-focused, and face-to-face peer-to-peer activities began to support a concept of 'peer counselling' and 'peer outreach'. These activities were presented as related to self-help groups such as Narcotics Anonymous (NA), and as experimental rather than specifically detailed.²⁷⁹ The term 'self-help' group was treated for a period as synonymous with 'peer group'. The terminology implied, in a drug treatment context, that non-professional, community-based counselling was provided by ex-IDU, as in NA. However, 'self help' in a gay HIV/AIDS counselling contexts held no implications of promoting obligatory abstinence.²⁸⁰ Such strategic slippage and differentiations provided opportunities for those who wanted the motivation change aspects of IDU outreach and education, as well as a segment of syringe supply, to quietly evade the abstinence models of the drug treatment clinics.

The timing of these cycles is again shown to be important. IDU did not need to struggle forcefully to escape the conventional logics of enforcement. Instead, their representatives and supporters fitted into a pattern, established by gays before them, of rejecting motivations of fear, and being unable to be forced into treatment in any affordable way. Offering financial inducements for compliance would seem likely to have decreased the support of the public while increasing the

277. See Baker (1987c), AIDS Advisory Committee (1988).

278. See Neaigus et al. (1990), Dolan (1989), Read (1988), Moran (1988), Moody (1988), Mundy (1988), Kerse (1988a, 1988c, 1988d), Wright (1988a), Friedman et al. (1987), Dolan (1986).

279. The ambiguity between frameworks of harm reduction or abstinence, and lack of details over methods and evaluation, would have made such concepts difficult to critique in an urgent situation of 'something has to be done'. It appears actors were making things up as they went along. See Tilly (1997b: 51-108), Stinchcombe (1997: 387-393).

280. See Wright (1988b), Payne (1988), Newmeyer (1988), Friedman et al. (1987: 1).

costs and administrative difficulties of the NEP. Decriminalising of illicit drugs was not considered as a harm reduction tactic, since that would work against the more general health policies of decreasing the rates of illicit injection. Any offer of drug decriminalisation might well have motivated IDU, but would have risked alienating the general public support for undertaking partnerships between IDU, officials, politicians, and professionals. The following stage therefore oriented upon a concept of facilitation, rather than of necessity or inducement.

3 Establishing IDU centres: From counselling to syringes

How did the logics of outreach that were to extend from the sites of professional expertise found in the clinics and the pharmacy outlets come to support peer-run contact centres? The logics of the NEP situation, deriving from the longer-term institutional situation where criminalising was constructed alongside yet separated from medicalising, required that working arrangements for the prevention of HIV/AIDS would somehow involve the voluntary participation of IDU. These logics notwithstanding, the IDU peers were not positioned for offering motivation changing services since they were 'criminals by intent'. Most IDU peers were not qualified professionally.²⁸¹ Their illicit experiences were not evaluated as useful, beyond the offering of advice and the provision of easier access for the referral of IDU to 'real counselling'.

After the NEP began operating in May 1988, the attitudes and behaviour of the IDU clients who participated increased in significance from the perspectives of the administrators, whose own performance was evaluated according to such outputs. In the same process, the occupational importance of the potential exchange process between the IDU peer workers and IDU clients was strengthened. This indicates how the timing, of first a pharmacy exchange for injecting equipment, and only then of a debate around competing models for motivation change, weakened professional claims to this territory more than would have been the case if the same changes had been considered together. After these initial stages had begun to make the IV League proposals seem somewhat more reasonable to the NEP officials, a workshop on IDU and HIV/AIDS was held in the beginning of June (Read, 1988). Some quite differing perspectives emerged from this workshop when the formal proposals by Dr. Baker and the IV League for outreach programmes were discussed.²⁸² A second type of IDU peer voice first appears in the records.²⁸³

281. Any that were qualified but also remained 'peers' through continuing drug injection took great pains to not be exposed as such.

282. The NZAF seems to have expressed its position, but whether as a specific NZAF model, or perhaps a general principle of participation of affected communities in programme design and delivery, was not recorded. Australian outreach experiences were also presented. Some programmes were centred around user's homes. Syringe supply was free and exchange was not necessary. A range of syringes was available in a six-pack. No client information was recorded. Programmes had been established in 1987, with funding of \$137,000 per annum.

283. These people later founded ADIO. An account from an ADIO founder indicates that this group's proposals were criticised by IV League personnel (Watts, 2004. pers. com.). Since there were no reports of an IV League presence in Auckland, the ADIO group's plans and clinic connections would have suddenly appeared as a threat to an

The AIDS Advisory Committee models of IDU education had involved fully professional counselling by means of expanding the existing clinics and GP-based drug treatment programmes, and by creating new mobile clinics. However, these options involved prohibitively expensive wages and start-up costs (Stoke 1987a, 1987b). These options also required significant incentives, for instance of drug maintenance or money, to counter the suspicions and requirements for anonymity that motivated IDU.²⁸⁴ Offering incentives to IDU seemed to counteract the logics of user-pays, complicated the preferences of the service deliverers for minimal paper-work, and opposed the preferences of planning officials for the lowest costs and least involvement by state agencies.

Dr. Baker proposed that the NEP's range of outlets and products be expanded, and that surveillance over the distribution patterns of injectable drugs take place. He promoted the provision of educational resources, outreach programmes, and self-help organisations as strategies leading to behavioural change. Dr. Baker wanted to extend the NEP into specific populations of prisoners, younger people, occasional IDU, and also into non-IDU communities, since: "The challenge is to establish an effective partnership between the community and the user/ex-user population to recognise and control the AIDS hazard which faces both groups" (Read, 1988). According to Dr. Baker's model, the government would provide syringes, fund IDU organisations, and embrace a harm reduction philosophy. Users would reciprocate by co-operating with the governance and evaluations of the NEP, and by establishing publicly accountable 'self-help' organisations.

Dr. Baker's argument for a 'partnership' model seems inherently contradictory in relying on clinics to provide the material and geographical bases for outreach activities. Drug treatment at the time was opposed to the logics of harm reduction.²⁸⁵ Furthermore, clinics were uncontrollable because they were mostly privately administered, somewhat like 'treatment fiefdoms'. Expanding their services would involve the difficulties of motivating the private sponsors and entrenched leadership of existing systems which were not competitive. However, one advantage of at least utilising such clinics lay in not directly challenging the biopsychological models favoured by the addiction treatment professionals. Another potential benefit came from complying with the medical professional requirements of the AIDS Advisory Committee. This Committee was understood by other medical specialists to be advocating that all aspects of the scheme should be centred on and controlled by a new type of mobile clinic or existing treatment clinics (Baird, 1987). Despite these potential benefits, the dependence on clinics specified in Dr. Baker's proposed partnership seemed to entail a pervasive logic of perverse outcomes.

established set of national arrangements and actors.

284. See AIDS Advisory Committee (1988), Stoke (1987a).

285. Hamner was the only clinic recorded as being prepared to become a supply outlet, yet only if not publicly advertised as such. National provision of counselling seems dubious if the centres had to be as secretive as the IDU clients. For discussion of drug treatment through abstinence in New Zealand see Jenner (2001), Van Kuppevelt (2000: 25-29, 32-33, 101-103), Collins (1988). For Hamner and the NEP see Crawford (1988a, 1988b).

Dr. Baker (1987c: 3, 12) had recognised that IDU would need to be strongly motivated to attend clinics, as required by his partnership model. He had suggested offering easier access to methadone as an incentive, but such inducements had been labelled as ethically unacceptable by a dismayed treatment specialist.²⁸⁶ At the time, methadone was presented as a curative treatment, not a maintenance, nor palliative, nor a harm reduction treatment (Jenner, 2001: 23).²⁸⁷ Medical treatment could not, at least formally, be offered as an incentive for behaviour modification, since that would distort the evidence base of diagnoses of relapse, improvements, or cure. Dr. Baker's proposed partnership model also suffered from having no material centre of activity and status to be controlled by the partner with the most choice and motivation about participating. This would have provided an incentive for continued participation by IDU.

The AIDS Advisory Committee did recognise some of the inherent problems of attempting to motivate IDU to attend motivational sessions at clinics. The Committee's solution was to provide financial incentives, rather than inducements based on collective social interactions such as greater recognition and representation. The Committee had previously valorised collective social interactions, and downplayed an individual focus in its rationale for providing educative counselling rather than syringe supply alone (Meech, 1987e).²⁸⁸ GP counselling was generally supported by all participants,²⁸⁹ but is not discussed here, since only a few GPs stated an interest in providing NEP services, and none remained in the NEP by 1994 (Walker, Brady, & Baker, 1994).

How the IV League understood counselling was also open to different interpretations. IV League spokespersons stated that there was a need for peer-to-peer counselling, according to the Community Health Outreach Worker (CHOW) model from San Francisco (Wright, 1988a). The League also promoted 'self-help' educators (Wright, 1988b) who were to draw on the locally developed NZAF counselling methods. These proposals suggested that 'self-help' organisation would overlap with the NZAF training and accountability systems, at least initially. The League emphasised that many IDU were, for a range of reasons, less resourced than gay men in terms of

286. A Royal New Zealand College of General Practitioners spokesperson commented: "Regarding Methadone programmes, I am dismayed at the comments made. It has some of the hallmarks of entrapment and I think should be reworded if at all possible. I agree with the need to spread the word through the "drug grapevine", but it would be inappropriate and counter productive to put up Methadone programmes so that contact can be made with I. V. drug abusers by giving them Methadone" (Seddon 1988: 1).

287. Methadone could not be offered as a bribe to induce compliant behaviour in IDU, without calling attention to how the barriers blocking access to methadone acted as a socially approved disincentive based on denying treatment to the sick. This is an example of a 'mechanism' where social and material alignments create social action. A mechanism is a parsimonious way of explaining both change and stabilities through the same process.

288. The inconsistency in this AIDS Advisory Committee stance appears worth exploring in a different study.

289. Arrangements for GP counselling had an unintended effect that was unwelcome from the perspectives of Department of Health officials. The proposed reimbursements for GPs encouraged pharmacists to reopen the question of their own professional fee component in the mark-up on the selling price of the packs. GPs who counselled and exchanged syringes from their practices were to be eligible for a special compensation under a 'Triple S' programme. If those providing Triple S funded services worked half time (20 hr week) for 45 weeks a year, as the workload on the Outreach counsellors was projected, their yearly income would have been \$67,500, compared with a yearly income of \$11,500 at AIDS Foundation Counsellor rates (Baker 1987c: 76). The Department of Health had strong financial incentives to provide counselling at AIDS Foundation rates, or below.

their capabilities of organising (Wright, 1987). The publications of the League did not claim that IDU were incapable, since they also emphasised the prevalence of recreational users and corporate users (Wright, 1988b). However, it was made clear that such socially accomplished IDU would not provide their organising skills if that entailed the costs of losing employment and social status by being publicly exposed as deviant.²⁹⁰

The IV League agreed with the AIDS Advisory Committee that syringe supply alone was inadequate until all IDU were consistently using new syringes. The League's proposals aligned with the Committee's in promoting the diffusion of safe injecting messages through IDU networks, and in providing education and referral services for IDU. Nonetheless, the League differed in promoting motivation change in order to build self-esteem. Self-esteem would help overcome barriers, such as social rejection and stigma, that blocked greater control of injecting hazards but could be overcome through harm reduction methods (Wright, 1988a).²⁹¹ The League promoted the empowerment of IDU. The League concepts of drug counselling were in places separated from HIV/AIDS counselling, yet conflated in other places. This was because the League supported conventional drug treatment for those wanting it, but otherwise supported harm reduction concepts of IDU gradually increasing their control of on-going drug use. What the League meant by HIV/AIDS counselling, in a NEP context, combined several different concepts, yet has seemed clearly different, in being outreach-oriented, from the professional counselling for support, testing, and prevention provided by the NZAF. The IV League proposed employing three full time and twelve half time staff (Wright, 1988a), three more full-time staff than Baker had proposed.

The attendees at the NEP workshop in May 1988 had generally agreed that people with credibility to the IDU consumer group should be responsible for the design and delivery of the programmes. These people were to be empowered separately from the drug clinics, although they should have full access to the resources, information, acknowledgements and financial support provided for drug clinics (Read, 1988). The IV League was considered by some attendees as being just such a representative consumer body, and as being suited for providing the desired services under discussion. However, the attendees were uncertain about the specific standards required for delivering services. Some also disagreed about IDU being represented by a single organisation with an overt political agenda. An alternative argument that emerged was that the IV League was not the

290. It has been noticeable that the strongest advocacy on behalf of criminal IDU and gays has come from those who were either or both, and were HIV positive. These people had little to lose by publicity. They could not be offered inducements apart from what they were demanding anyway. They could not be cowed by threats to their well-being. Nor did they need to fear being prosecuted. For instance, a press clipping in the Department of Health files of the National Archives records that: "Charges of importation of a Class A controlled drug were withdrawn against a 39-year old Wellington man because he's dying of AIDS" (Unsourced, undated [my ref 4-79]). Even at their most provocative, it was far more more upsetting for officials to have HIV positive AIDS activists arrested than to adjust to their demands. Arresting a PWA meant that state agencies would become fully accountable for their care and continued well-being. Nor would such arrests promote a partnership model. HIV/AIDS activists were safe from arrest in New Zealand, and could concentrate on achieving policy advances.

291. The IV League considered that rates of drug dependence would also drop through empowerment strategies.

only or the best way to address the problem of motivation change, since some IDU felt alienated by its high profile. Other voices called for transitional arrangements before giving full responsibility to the IV League (Read, 1988).

The workshop attendees recommended that Community Health Outreach Workers (CHOWs) and a national outreach co-ordinator be employed, but did not specify by whom, nor the framework of accountability. Nor is it clear that the participants meant the same thing by referring to CHOWs, since the concept as used overseas entailed street work in a type of street drug scene that did not occur in New Zealand. The options for providing the best oversight for the proposed outreach services included the Department of Health, a national co-ordinator, a regional advisory co-ordinating committees, and a national body of regional committees (Read, 1988). It is clear that centrally co-ordinated funding and direction was supported by all the participants. The attendees also agreed that oversight by a Committee that was close to the actual level of service delivery was desirable, though such a Committee would only act in an advisory capacity, not directive.

The attendees did not articulate any clearly desired governance structures for the evaluation and accountabilities of outreach services. Only general goals and principles were proposed. Apart from peer workers who were trusted by IDU having guaranteed input into the administration, no strong single preference for the shaping of such goals was expressed. These goals could potentially be attained through different assemblages of logics and methods, using bureaucratic, market, and professional models and mixes. The different interests and potential directions stand out because they were not submerged in a common framework of expertise and understandings. Nobody could show qualified expertise, nor clearly effective success, or even significant experience, in NEP outreach, motivation change, or counselling.

The workshop illustrates the significance and inseparability of the timing and boundaries. The activity over the boundaries of jurisdiction of the medical and treatment professionals produced enough force to demand government investment in conventional 'counselling'. That force, expressed as a need for counselling, was not enough to delay the legalising and implementing of the NEP syringe supply.²⁹² This deferred the conflict over the goals and methods of motivation change, which by becoming labelled as 'counselling', undermined the concept and drew attention to the paradoxes implicit in conventional drug counselling.

The contesting elements then came together at the workshop, where ideology-based arguments needed to engage with an actually operating syringe exchange programme, with its inbuilt evidence-based evaluation, its support from a state of public urgency, and its official codes of approval. Since no unmanageable problems had been reported through the recently established yet

292. For instance, there were calls at the working party for a programme of civil disobedience over the 16 year age restriction on syringe sales (Read, 1988). The age limit seemed as if moral considerations were putting the lives of younger IDU in jeopardy, while causing unnecessary legal risks for those selling the syringes (Baker, 1987c).

actually existing system of NEP monitoring, it was far easier to wait and see what further epidemiological and infrastructural data might indicate before arguing for major changes. By providing monitoring services, the NEP arrangements altered the frameworks of the logics of the different methods of counselling IDU. The logics of NEP hybridity were given time to be adjusted to by actors within the network of connections being assembled.

The two goals of the NEP are seen to have consolidated in concept, but at different rates, in discontinuous streams of activities. The syringe supply stream was being implemented on the ground, but not the 'motivation change' stream. The connections between these streams had not been made mutually reinforcing in symmetrical, simultaneous ways. Instead they contributed to each other in an asymmetric, 'alternating' way. The tactics of managing consent involved deferring the aspects likely to be opposed to a time when the monitoring of information and new developments had changed the frameworks of logics involved. Furthermore, the number of elements requiring new arrangements, including CHOW activities, physical locations, accountabilities, employment protocols, and IDU involvement, took time to find suitable representatives. These arrangements were not initially attached to any substantial theory or model, which could have assisted in co-ordinating the understandings and expectations of participants into a working set of arrangements.

All the elements that became attached became linked to the pharmacy-based supply of syringes, because there was no other institutional vehicle at hand. Due to the prior conflicts which gay activists had largely won, the planning terrain was conducive to the logics and models of participation. These aligned readily with the pragmatic tendencies of official planners and pharmacists. The participants had no rigid social structures to rearrange, since all the participants accepted that the stage for operating could be small and experimental. There was a set of problems potentiating a solution, and a set of existing arrangements available for reconfiguration. However, the critical elements were not drawn from a generalised background into juxtaposition in the crowded 'historicised' foreground by impersonal forces. The reconfiguration involved strategically positioned, motivated participants, aligned with centres of calculation, medical knowledge and syringes, as part of the network activity that came to create the peer-run contact centres.

4 Two sets of IDU peers bid for official patronage: Lowest bid takes all

In the previous phase of activity in which the positioning of IDU and peers had altered, IDU had been acknowledged as NEP customers, rather than as patients of doctors or clients of professional expertise. In the next phase of activity, from May to September, several conflicts played out at around the same time. In one conflict, two different sorts of peers, using different sorts of

organising methods, influenced the political problem of providing counselling for IDU. However, I will first discuss how a related conflict has illustrated issues of expert knowledge which have pervaded the NEP's relationships between peer embedment and professionalising.

This conflict involved a dispute over jurisdiction between the NZAF and the Medical and Scientific SubCommittee on AIDS (MASCA),²⁹³ over their respective knowledges and organisational status. MASCA was chaired by Dr. Meech, who had lobbied strongly, as a key medical advisor, for point-of-sale professional counselling at all NEP outlets. The NZAF was important in being a potential model for providing counselling and peer outreach services, as well as being a powerful lobby group that strongly supported the NEP and models of peer participation. The AIDS Advisory Committee and MASCA had remained important sites of activity after the NEP legislation changes, even if less crucial than before.

MASCA took a position that supported the privileges of biomedical-based professionals to control medical knowledge and advice by excluding the voices of those affected by such knowledge and advice.²⁹⁴ This stance was supported by Department of Health advisors and the Minister, who denied requests by the National People Living With AIDS Union and the NZAF to guarantee a seat for an HIV-positive representative on MASCA. Instead, the Minister and advisors supported a separation of expertise on HIV/AIDS into two committees.

MASCA presented knowledge on 'nature' from a science perspective. The National Council on AIDS offered a social commentary from a notably wide-ranging, representational perspective. The AIDS Service Organisations opposed such separation. They supported the inclusion of the social expertise and 'lived experiences' of members of marginalised groups into all perspectives, especially into biomedical perspectives. This conflict over knowledge, representation, and trust was significant in how it provided reasons for the AAC's insistence on professional counselling.

There were two aspects of this environment of advisory expertise that resisted being categorically

293. The AIDS Advisory Committee had been scheduled to be renamed the Medical and Scientific Committee on AIDS (MASCA), alongside a National Advisory Committee on AIDS (NACAIDS). From an AIDS Advisory Committee perspective, MASCA was the only source of expert knowledge. NACAIDS was considered "a public relations gimmick" (Dowling, 1987a). However, during developing conflicts over representation, NACAIDS had become reconceptualised and renamed as the National Council on AIDS. MASCA became repositioned as its subcommittee, and renamed accordingly (Poutasi, 1988a).

294. The National Council on AIDS expertise was socially oriented, whereas the subcommittee was medically and physiologically oriented on individuals and aggregate populations. However, it proved difficult to maintain such distinctions, despite the Director-General of Health stating that the two different types of expertise conflicted, and accordingly, were more effective and efficient when separated as two distinct advice streams. See Poutasi (1988a, 1988b), Fielding (1988a, 1988b, 1988c), Caygill (1988a, 1988b). This formulation was rejected by advocates of each stream, each of which was claimed to be more significant than other. Dr Meech stated that social aspects could not be separated from medical aspects, yet that such medical advice must not be altered by non-medical people and perspectives (Meech, 1988a). HIV/AIDS activists stated that non-medical comments must accompany any medical advice, given the harm such advice could potentially cause to social programmes (Fielding, 1988a, 1988b, 1988c). It appears that each perspective preferred to control their own advice stream, yet needed to know immediately what was being said in the other stream in order to comment on it at the time, rather than later. This meant they needed to control their access to the other stream. The distrust between these two courtier-like factions forced them into mutual engagement, despite the Minister preferring them separated. Contention over membership of MASCA was

repackaged within tidy committee boundaries. The National Council on AIDS became responsible for monitoring and advising on HIV/AIDS prevention work with IDU (Pearson, 1988), though not on curative or physiological matters. However, the AIDS Advisory Committee also recommended, during its reallocation of responsibilities on its disestablishment in March, that all NEP information continue to be sent to MASCA as well as to the National Council on AIDS. No reasons were offered.

The second surprising aspect involved medical professionals who became HIV-positive. The reports relating to these cases were to be sent to MASCA, but not specified as also to be sent to the National Council on AIDS. This directive suggests that at least some of the social aspects of medical worlds and social groups of medical personnel were claimed as falling within a medical jurisdiction. These aspects touch on an elite type of status, in particular that involving occupational roles and situations being specifically excluded from the wider public collective and particularly from being subjected to different expert disciplines of social analysis.²⁹⁵

These exceptions illustrate how issues of control over treatment practices created or reinforced a line of division between the juxtaposed committees, yet also maintained a connection of contested privilege between them. The conflict provides a context and motivations for how the NEP was understood and positioned as an object of contention between different types, organisations, and occupational divisions of expertise. Such conflicts inform the manoeuvrings over the configuration of the NEP's counselling goals, requirements, and methods.

The conflict over NEP counselling did not seem directly affected by the NZAF as an organisation. However the conflict did illustrate the dangers and risks, from a Departmental perspective, of too powerful a 'lay' community voice, even though such officials also opposed a too powerful 'professional' administrative voice. This conflict coincided with attempts by the Department to restrict the expansion and influence of the NZAF (Kemp, 2004). In this climate, the Department officials had an interest in preferring peer group models that did not follow an NZAF pattern, nor were 'locked-into' the NZAF in other ways.

After arranging the NEP workshop discussed in the previous section, Kerse contacted a variety of sources of expertise to gather information about the requirements for organising outreach programmes. She approached Marion Watson, who directed IDU education and outreach in Canberra (Kerse, 1988a, 1988b), and was approached by Robert Kemp,²⁹⁶ who worked as an ex-

inflamed by Dr. Say's appointment after being nominated by the Venereological Society. HIV/AIDS activists objected because Dr. Say had publicly lobbied against decriminalisation of homosexuality, and continued to lobby against gay rights (Fielding, 1988a, 1988b, 1988c).

295. One imagines issues of medical professionals becoming drug dependent, and/or injecting recreationally, would also be placed under 'medical' rather than 'social' control in being judged by committees of colleagues rather than Crown prosecutors and judges.

296. See Kerse (1988d), Kemp (1988a, 1988b, 1988c).

IDU at the Auckland Methadone Clinic.

Kemp proposed an outreach model that selected aspects of the previous proposals and integrated them in a new assemblage. This assemblage was to be a stand-alone Trust called the Auckland Drug Information Outreach Trust (ADIO). ADIO was similar to a treatment clinic in its professional supervision and networking, yet its services were delivered by IDU peers. There are no archived records of any equivalent correspondence between the Department and the IV League or MASCA. It may be that they were not aware of these negotiations. It may be that the Department had already indicated its preferences and had waited for somebody to offer a means of implementation from the private sector. The evidence here is open to different interpretations. Nonetheless, it is clear that Kemp's proposal was strategically timed. By being presented after the alternative models, it could critique them, and be closer to the crucial decision point.²⁹⁷

In early June, 1988, shortly after the workshop, Kemp wrote to Kerse, criticising the previous proposals for providing motivation change services. Kemp argued that: "Rodger Wright's proposal would require excessive human and economic resources. Michael Baker's proposal utilises too few people" (Kemp, 1988c). If Kemp's model was applied in five urban centres, the costs would be \$42,145 per annum, less than the IV League proposal and equivalent to two full time staff.

Peer Counselling Proposals between 1987 and 1988

Table 4a.

Who	Site Ownership	Personnel numbers	Year Costings	Based	Time
Baker. Department of Health official.	Department of Health. Private clinics	6 half time.	Not offered.	In drug treatment clinics in all 5 major cities.	Dec. 1987
Wright. IV League.	Department of Health. Private clinics.	3 full time @ 28,750 12 half-time @ 14,039 Total	\$ 86,250 \$ <u>172,500</u> \$ 258,750	Connected to drug treatment clinics in all 5 major cities.	Feb. 1988
Kemp. Methadone Clinic proponent.	Private 'shop front', contact centre.	1 full time @ 20,800 1 half time @ 10,400 Office rent Running costs Total	\$ 20,800 \$ 10,400 \$ 4,160 \$ <u>6,961</u> \$ 43,321	Auckland only. Would cost \$216,605 to extend to all 5 major cities.	June. 1988

Kemp's model relied on there being fewer part-time workers, which indicated that higher professional standards would be required from those employed. Another important difference

297. Past that point it was free from having to compete with alternative models that had been improved by its own features and critique, similar to releasing policies too early in an election.

consisted of the lower pay rates for full time and part time employees. Kemp's argument, in effect, was to create a more professionalised workforce with less outreach activity employed at lower rates in a pilot project that could be easily abandoned if not proving to economically or administratively viable. Kemp also argued that both the overseas and local gay community models were inappropriate for working with IDU in New Zealand.

Kemp instead promoted flexibility and regional expertise within a national framework for: "Contacting and building up a network of local consumers or collecting raw data for national research" (Kemp, 1988a: 1-2). Kemp's proposal did not require committing any set level or type of employment or expenditure. It potentially incorporated Baker's concept of partnerships and research, as well as the IV League's concern for inclusion of peer expertise. It also included the MASCA demand for providing motivation changing counselling services, although not at point-of-sale in pharmacies. Instead, Kemp added the provision of after-hours exchange services to his original proposal. Counselling was not to come to the syringe exchange, instead the syringes would come to the peer group's motivation change and educating activities.

Shortly after receiving encouragement for the ADIO proposal by Kerse, Kemp attempted, unsuccessfully, to become directly employed by the Department. His proposed job description was to help in overcoming the opposition he had experienced when promoting ADIO's type of work (Kemp, 1988b). Although Kemp did not propose that there be a formal hierarchy to administer a collection of 'ADIOS', he did emphasise the need for high-level, Wellington-based, national co-ordination, presumably for more than a single urban pilot study. The person evaluating this proposal shortly became employed by the AIDS TaskForce as just such a co-ordinator, as Kemp himself later became, though in a more advisory role. Similar career interests and opportunities meshed with the organisational framework of the proposal. The proposal for ADIO as a peer group contact centre was extremely experimental and risky, but also cheap, while providing invaluable career experience.

The sequence of archived correspondence shows that the ADIO proposal rapidly became favoured by Department planners. It received strong support from the Nurse Administrator of the Auckland Methadone Clinic (Moody, 1988). Kemp stressed the need to employ women, due to the connections he emphasised between IDU activities and sex work. By not being linked to the IV League, nor formally to the NZAF, nor to medical professionals, Kemp and ADIO avoided the existing conflicts, such as those I have described that emerged between the Department and the NZAF.²⁹⁸ ADIO received a funding contract and established a new service delivery model as a

298. In February, 1988 a Department official on the NZAF Board was forced by the Department to resign due to perceived institutional conflicts of interest, against the firmly expressed wishes of the NZAF (Lindberg, 1988a, 1988b). This official sat on the National Council on AIDS as the Department of Health representative (Poutasi, 1988a). The NZAF model of community participation through an NGO had framed the provision of services and policy advice since 1985. Due to its success, the NZAF developed from a gay alliance opposing control of HIV/

contact centre. This did not constitute a commitment by the Department to consider ADIO as a preferred model or the only source of expertise on outreach. Instead, Kerse continued to gather information from international sources about different outreach programmes (Kerse, 1988f). The contract was adjusted before signing to include the provision of after-hours syringe exchange services. However, ADIO was particularly significant in its timing, since a very similar model had already been rejected early in 1987. The 'shop-front model', which it closely resembled had not been initially shortlisted as a model for syringe exchange. ADIO was a repeated idea, not a new idea.

In February 1987, a Departmental analysis of prospective NEP arrangements, presented at the 'Police/Customs/Health Dept Working Party on N&S for IDU', had briefly discussed the principle of new clinic sites (Stoke, 1987b). These were not presented as drug treatment clinics, but were termed 'AIDS Shop Fronts' that involved outreach. This was one of the first proposals that mentioned outreach as being different from professional drug counselling.²⁹⁹ The trial nature of this shop model is clear, as are the peer engagement aspects of its services. However, the police perspective that outreach would involve "a 'plain clothes' health care worker in unmarked [sic] car" (Stoke, 1987b) might explain the overall recommendation of the working party to "wait".³⁰⁰

By June, 1988, Department officials had shifted from 'waiting' to more directive activity. Kemp notes that:

as government activity in providing HIV/AIDS services grew, it became inclined to view the growth and encompassment of the AIDS Foundation with some suspicion. This led the AIDS Taskforce (Dept. of Health) to develop, in the words of one official, a process of "contrived spontaneity", whereby members of marginalised groups would rather miraculously appear as fledgling organisations seeking funding. (Kemp: 2004)

In 1988 the concept of 'shop front' contact centres became favoured for counselling and education due to the invisible hands of 'contrived spontaneity'. However, in 1987 none of the working parties had short-listed the the shop-front concept for implementing syringe exchange. As late as 1990, a review of the peer groups suggested that the degree of syringe sales through the peer groups was too low to be of significant value to IDU consumers, and was not worth subsidising (Robinson,

AIDS by medical professionals, to a more complex and stratified professional organisation opposing Department officials over the rationing of funding. Kemp (2004) suggests that Department officials in 1988 were restricting any expansion of this model.

299. Outreach in these terms was conceived of as connected to drug user networks, and as avoiding the problems of the established types of methadone programme. But any proposed links between the NEP and the existing programmes run by drug treatment professionals were thought problematic, since harm reduction was generally not supported by the established drug treatment specialists. The working party had noted that the established drug clinics and GPs had the most support to supply syringes, since the police approved of these two options and the AIDS Advisory Committee considered that counselling at point-of-sale was feasible. However, neither drug clinics nor GPs were considered affordable, which partly explains why the pharmacy option was later selected. Perhaps some participants were manoeuvring for new clinics once costs were better known and the unforeseen consequences of an innovatory programme had stabilised.

300. It perhaps supports a concept that some Department officials had a long-term plan involving community groups of some sort running needle exchanges without professional levels of wages, and without opposition from enforcement agencies.

1990: 25-26). This evaluation illustrates how the shape and pace of the NEP developments were uneven, despite the careful Management Plan. Significant later developments, such as the numbers of syringes supplied from thirteen peer groups overtaking the syringes supplied from over a hundred pharmacies, were neither predicted nor encouraged during the first two years of the NEP.

To operate as an exchange, agreements had to be made for ex-IDU and IDU to be officially approved of by local District Advisory Pharmacists as NEP salespeople. This issue had been contested by GPs, treatment specialists, and pharmacists, who all considered that their professional qualifications were more than adequate to ensure their suitability. Nonetheless, the Department officials disagreed, knowing from the IDU peers and their consultation with health professionals that strong prejudices against IDU existed among professional groups. Accordingly, the Department officials wished to be able to rapidly expel any professional who seemed to bring the NEP into disrepute with IDU. This rankled with professionals, since a state agency was superseding their jurisdiction over their qualification requirements in work situations. The ADIO model positioned professionally the unqualified and illicit IDU as equivalent or even preferred to professionals for becoming a type of NEP specialist.

The contracting of ADIO constituted the second professionalising step made by IDU peers. The first involved becoming attached to the organising of gay-focused HIV/AIDS prevention, as an IDU concern within the AIDS Service Networks, then later within the NZAF. Such lobbying separated into a more intense, focused organisation with the establishment of the IV League. The second phase of arrangements following from the establishment of ADIO were more professional than the League, at least partly because the methadone clinic background provided effective and efficient knowledge of how to set up and run a small, isolated health education unit, and how to liaise with treatment clinics.

However, ADIO remained dependent on its continuing engagement with IDU expertise and backgrounds to provide its legitimacy and to avoid competition from treatment and social work professions. Yet as a result of ADIO's contract with the Department of Health and the principle this established, IDU who did not operate in an IV League mode of public politics gained opportunities to discretely enter a new type of work and to accumulate in number, while establishing boundaries and connections. The output was injecting safety but the outcome was a new occupation of peer-professionals.

This step had come about because clinic-based 'ex-IDU' Aucklanders challenged the IV League's claim to represent IDU voices and organisation. The League had previously been aligned with the Department of Health in achieving a pharmacy-based NEP through legislative change. The League had specialised in political lobbying, but control of the legalised NEP shifted from political to

bureaucratic areas. ADIO members had clinic-organising competencies, commercial associates, and seemed better at networking in bureaucratic situations. Their managerial and analytical capabilities became trusted by Department officials, which undoubtedly helped in gaining a contract for their model, which was rapidly copied by IV League members in other cities. These IDU experimented with combinations of small IDU volunteer networks, administration systems, peer groups, and the clinic model (Robinson, 1990). In consequence, these IDU peers became more trusted by the Department officials and increasingly treated as professional service providers.

Christchurch IV League members effectively stopped working and behaving as the IV League when they copied ADIO's organisation. They were directly assisted by members of ADIO, and were occupationally shaped by the requirements of ADIO's type of contractual relationships with the Department of Health. IV League members who started peer groups in different cities arranged for supportive clinic personnel to sit on their Trust Boards. Meanwhile, ADIO began to exhibit more peer activity than in its initial period of gaining the trust, and a contract, from the Department. There seems to have been a diffusion of practices in both directions. IV League political interests seemed to have been excluded from Department negotiations during this period of change, yet became more flexibly and capably expressed through peers running outreach shops, while ADIO gained national resources and influence through a network of peer groups that rapidly expressed solidarity as allies against common problems. All these parties wanted improved methadone and other drug treatments, wanted official acceptance of harm reduction, and wanted evidence-based drug use policies. They also wanted to place HCV transmission onto the political agenda, despite official disinterest.

These developments may not have occurred if MASCA had not demanded obligatory counselling at point-of-sale, or if many other 'chancy' factors had not contributed to a unique cultural, political, and geographical environment. The aspects of the development of the NEP are explainable in terms of wider conflict theories,³⁰¹ even if the outcomes in any situation were unpredictable. The MASCA proposals to lock-in a programme that institutionalised funding for a professionalised counselling service seems understandable from a perspective of territorial jurisdiction. After all, the HIV/AIDS gay activists had used a similar tactic to institutionalise the funding of programmes under the control of community organisations. But although these tactics were equivalent, the outcomes were not.

The MASCA rationales were based on public health promotion, although also clearly professionally self-interested. Such self-interest, combined with public well-being, and also with a health professional's distrust of government expediency,³⁰² was shared by some Australian health

301. See Immergut (1992), Abbott (1988, 1992a).

302. Wodak had written: "Although I am not opposed to this [supply only] system backing up other outlets which emphasise needle and syringe exchange, we now have the ghastly prospect that the Government policy may

professionals (Wodak, 1987). As the threat of HIV transmission was seen as less urgent, New Zealand governments and state agencies reduced the NEP's budget during the early 1990s. These agencies ignored forms of health provisions that were not self-funding, such as HCV prevention and outreach in general. The continuation of IDU services became reliant on the voluntaristic ethos of the IDU peers along with support from allied AIDS service organisations.

The NEP developments have illustrated the difficulties encountered when principles of medical and biomedical treatment come to be applied to public health and state policy. Medical ethics demand that practitioners treat human needs in actual practice, whether or not a theory is available. The requirement is to 'treat all'. But does that include those who do not wish treatment? This principle, or logic, potentially conflicts with another medical principle of 'first do no harm', and accordingly, requires expert trained discretion in application, as well as funding to meet the costs of treatment, training, and supervision. The MASCA proposals in 1987 and 1988 were never realisable in that financial and political climate where state agencies were rejecting the logics of health budgets being controlled by professionals, and rejecting the related logics of public health aspects of contagious diseases being provided through a centralised hierarchy.

As it happened, the AIDS Advisory Committee and MASCA were wrong about IDU attending needle exchanges needing professional counselling at point-of-sale to prevent HIV transmission. There were a range of reasons for their mistaken prognosis. One involved IDU exercising greater self-motivation, as individuals and networks, than those treatment professionals were capable of acknowledging. Another reason is that the printed education material, including the IDU magazines produced by the peer groups, helped in constructing a sense of a national IDU community. It is significant that the pool of HIV in New Zealand, after its testability became possible,³⁰³ began and remained extremely low. It also seems likely that the presence of IDU peers in the socially responsible, health-promoting occupation of HIV/AIDS prevention has contributed significantly to how IDU perceived themselves and their injecting practices. The representation of IDU in a

inadvertently be exacerbating the problem by increasing the stock of used needles and syringes in circulation. The politicians are unwilling to take that extra step to needle and syringe exchange because of the political cost" (Wodak, 1987: 1). Wodak had professional research interests in syringes being returned, having carried out several surveys that sampled returned syringes for HIV indicators. Wodak's work positioned syringes as a cheap and effective way of monitoring IDU health, but effectiveness and efficiency dropped if low return rates lowered the validity of the syringes sampled. A week earlier the Minister had written to Dr Meech stating that a law to increase the availability of needles and syringes was essential. In this letter the Minister wrote pointedly about: "a suggestion by the AIDS Foundation that a specific AIDS prevention education committee be established to develop a coordinated approach in this area. I am conscious of the fact that the AIDS Advisory Committee consists mainly of expert individuals rather than representatives of the wide range of organisations and government departments that must be mobilised in the fight against AIDS. Some concern has also been expressed to me at the lack of non-medical and non-technical representation on the AIDS Advisory Committee though I do not see this as a major criticism. I would therefore appreciate your committee's comments on the question of expanding the membership of the Advisory Committee or forming a separate advisory body to expand the scope of the AIDS campaign" (Bassett, 1987a). However, no law change would have been necessary if syringes were only available through prescription by health professionals.

303. This phrasing is to emphasis how without testability there was no way of identifying HIV as the cause of AIDS. There is no way of correlating or otherwise establishing strong causality, with an element that cannot be identified, and accordingly, cannot be 'presented' as being present.

national programme would have encouraged other IDU to think in terms of national collectivity and general principles of community health. Professional intervention was not needed in many situations because the 'patients' were interacting with each other in more professional ways. However, although the practices constituted a public health success, the diffusion of professionalism to lay IDU, and more so to the peers in the NEP, involved a loss of territory to conventional professions such as medical specialists and mental health/addiction specialists respectively.

Counselling had been demanded by medical professional and police. Without the arguments for counselling it would have been far harder to overcome opposition to the NEP from police and medical professionals on the AIDS Advisory Committee, who feared that HIV transmission would not be reduced through the supply of syringes alone. The Committee members had predicted that the exchange system would not work adequately. However, the system worked sufficiently well to almost eliminate HIV incidence among IDU, and professional counselling proved to be less necessary than initially claimed. The epidemiology of HIV/AIDS provides evidence that IDU were more capable and 'normal' than a variety of participants had supposed.

5 Autonomous peer groups 'transfix' the problem ... by not properly fitting

Medical professionals might have been expected to oppose the contracting of peers to provide professionalising types of services. However, a range of reasons why they could not are discussed in this section. In brief, the timing was fortunate for peers to professionalise, since the logics of the situation were hard to resist once a working model that illustrated hybrid NEP logics and methods became operational. The participation by marginalised communities in HIV/AIDS prevention had become a policy requirement. The AIDS Advisory Committee had to accept Ministerial decisions, and could not directly provide alternative services, nor control funding. The nature of the medical professional objections to peers involved their systemically underrating of the capabilities of IDU and peers. Consequently, peer-professional developments were not foreseen. Nor could medical professionals reasonably oppose a cheap pilot project that facilitated rather than replaced professional counselling.

The NEP developments in 1988 were founded on conflicting hybrid goals and methods. Department of Health officials had prioritised the public health logics of improving the safety of material environments by supplying and retrieving syringes. The AIDS Advisory Committee and drug treatment professionals had promoted the treatment logics that demanded motivation change. Both stances were supported in overseas literature on needle exchange experiences,³⁰⁴ which helps

304. These reports originated from practitioners who provided counselling, and were only compared with less successful exchanges in different regions or countries. Locational differences in IDU practices and clinic practices were not

to explain how these conflicting concepts of treatment and harm reduction became combined in the NEP. The Committee's attitudes defended the territory and status of the treatment specialists, but presented drug users as too foolish or irresponsible to learn to inject drugs safely without professional control. This conflicted with the pragmatic ambiguity that facilitated the enrolment of disparate groups such as IDU, whose voluntary participation as clients were required. The AIDS Advisory Committee tactics threatened the viability of a NEP by demanding higher professional standards. To resist this tactic,³⁰⁵ issues of motivation change were deferred until after the legislation change, and after a pharmacy-based NEP began operating. A consensus, supported by codes of practice, was established in stages.

Later in 1988, motivation change, linked to peer outreach, was presented as a complementary add-on to an ideal model of professional counselling linked to conventional drug treatment. Peer counselling was promoted as being more valid and accountable than merely a pragmatic, ad-hoc measure, yet was not presented as competing with the provision of expert professional services. This tactic successfully gained ADIO a pilot contract in Auckland for a year, then further contracts in other urban centres with increased funding for twenty years, and continuing. The success of this trial model appears partly due to problems being isolated and addressed close to their source, rather than flowing back to the Department of Health, and partly because the surveillance aspects of record keeping produced information about illicit drug use that could not otherwise be accessed. Such information could not be supplied by the IV League, because the League was not providing exchange services and had no systemic operations that could regularly collect surveillance information on IDU.

As general concepts of community empowerment seemed to health officials to be increasingly applicable and significantly affordable, developments such as the NEP diminished the control of established health professionals in areas where the drug treatment field overlapped with HIV/AIDS prevention. Existing professional programmes for drug treatment were offered extra resources as part of an integrated HIV/AIDS prevention strategy, but were not allowed to destabilise an NEP model based on IDU community networks. In these direct and indirect ways, peer participation became framed and reframed as possibilities and opportunities, rather than as a risk of lowering or destabilising the existing professional standards.

Since the existing treatment(s) for drug use were not considered to be sufficiently effective, and

considered. Nor was the counter-case that IDU could modify their own practices without interventions by employed experts. Overseas models were used to imply that in New Zealand, professional counselling must be obligatory, to ensure that equipment being provided was actually used in 'healthy' and cost effective ways.

305. In such tactical manoeuvring, all participants seem united in wanting effective and efficient outcomes. All also had interests that might support or oppose, and be supported or opposed, by how a NEP might be implemented, understood, and develop in unknown ways. I noticed that those participants who had HIV/AIDS spoke, wrote, and acted most directly, yet also that they were active for shorter times than others who redirected their work and influence after their deaths into less straightforward channels.

since most IDU already successfully avoided policing efforts, alternatives to abstinence and enforcement were required. Because of the way HIV acted within human and non-human vehicles, along material and communicative pathways, prevention tactics needed to be multiple. Because of the human and political urgency, the integration of multiple elements needed to take priority over the existing territorial boundaries. This realisation extended the arrangements developed several years previously around gay men, when gay community representatives forced themselves and their perspectives into the Minister's expert advisory committee.

The law changes in 1987 brought about new occupational opportunities. Since the pharmacists in the NEP already had an occupation, which they did not propose to change, new actors found opportunities to develop a counselling niche. This niche bordered the pharmacy NEP, but involved positions which pharmacists and conventional counsellors needed to avoid. Treatment professionals risked losing their existing claims to jurisdiction over expertise, legality, and occupational territory by becoming peers who associated with IDU, rather than exerting control over IDU. The connections between HIV/AIDS and drug legislation acted to detach the professional claims to expertise over IDU from the political accountabilities to protect the general public. The IDU peers drew on the principles and protocols developed through the gay community cycle. Despite their stigma the IDU peers gained in overt significance and status by the shaping of a NEP around its becoming acceptable to IDU, then on the increasing focus on IDU attitudes and participation in the initial evaluations of the NEP.

In 1988, pressures from medical professionals and police to provide specialised counselling led to a new set of paid and accountable peer service providers, in a new system of funding, monitoring and evaluation. These IDU and ex-IDU were employed to provide 'peer counselling', outreach, and to facilitate professional counselling. These developments led to IDU directly participating in the NEP as service providers for peer outreach counselling. This process was shaped and timed by a need for state agencies to provide for professional counselling in ways that fitted with the regulation of the pharmacy-based NEP, yet did not impinge on the commercial arrangements of pharmacists.

Several types of counselling were referred to in Department of Health reports from 1986 to 1988. Whether the type which peer groups provided was one of these, or a combination, or a new type, or actually not counselling at all, was extremely ambiguous and has remained contentious. Yet by forming organisations for this professionally justified reason, IDU peers also established an infrastructural capability to address absences in the equipment aspects of the pharmacy based NEP. The consequent modification of longer-term institutions and logics of health provision inform understandings of how IDU peers later became major participants in making policy.

The NEP might have developed without a notable interplay between peer and professional aspects, if not for beginning with such shifts in understandings, and being shaped over a period by changes in the local positionings of such actant³⁰⁶ arrangements. Medical, mental health, and drug treatment specialists responded to the distrust and non-compliance of IDU by ignoring and avoiding this reshaping of the NEP territory by viruses, drugs, IDU, pharmacists, legislation, and syringes working in combination. The absence of established professionals opened a window of opportunity for the provision of syringes by pharmacists, then by IDU peers, in experimental, hybrid occupational forms. The neo-liberal government policies of decentralising and commercialising the provision of health services encouraged organisational independence at the interface with communities.

Peers could work cheaply as after-hours volunteers in the evenings and weekends when IDU were expected to be injecting. Keeping used syringes for return made public environments safer, and increased the measurable NEP outputs, but at the cost of exposing IDU to arrest or harassment. However, peers could motivate IDU clients to return syringes simply by asking and approving of returns, in face-to-face interactions. Because of the IDU peer participation in exchange activity, the logic of the 'clinic' aspects of the NEP connected to the logics of the collective, networking aspects of illicit activity. Needle exchanges have been too delicate to alter such cultural arrangements, despite their success. Yet their success may be defined in terms of current perceptions of the distinctions between crime and health, whereas their organisation depends upon simultaneous engagement with crime-making, health-making, and law-making agencies.

In these ways, aspects of community representation and service delivery merged to a degree, while remaining as identifiable separate strands that were active in alliance, yet also in opposition. The creation of the NEP in 1987 allowed the underlying sustainability of peers as quasi-professionals to become apparent in the working out of political arrangements. During 1988, the framing and organising of the NEP moved to an 'internal', implementation arena of 'shaping' the terms of the

306. 'Actant' is an actor-network term for an effect or site of significant activity involving shifts in meanings and representational narratives. The activity is always interactive and an actant can never be alone. The consequent complexity draws attention to tactics of simplification and boundary-setting in practice, while rejecting claims of prior large-scale or universal entities that 'simply exist' rather than being interactive and changeable. This co-dependency of activity and entity, and consequent explanation based on experienced rather than postulated phenomena, radically works around the 'structure-agency' division within which many sociological understandings have been framed. This reframing is co-dependent on widening the metaphysical field beyond the Western Christian historical lineage that privileges unitary models in either personal or impersonal forms. Or subjective-objective binaries. In so doing, both foundational and accumulative structures are added to by network and self-maintaining structures, which dramatically repositions structure and agency in the same actancy, not only in grounded practice but also in conceptual representation of wide spaces and temporal durations. (See Chapters 2 and 3, and Appendix 9). The term 'actant' includes humans and non-humans in assemblages which drive and block activity, while actively maintaining or altering the conditions of possibility for potential activity. (In my opinion, this framing is shared by Buddhist lineages and is found in the practices of 'dependent origination' sometimes termed 'co-dependent causation'. In the Mahayana and Vajrayana traditions such practices emphasise compassion rather than dispassion.) Actants, accordingly, are the focus of actor-network analyses of how social-material actions can be co-ordinated and consolidated into understood events and effects. The term 'actant' does not necessarily denote self-conscious agency, unlike the term 'actor' and most sociological uses of the term 'agency'. However, the aspects of agents and agency that involve representation overlap with actor-network uses of actants. See Latour (1987: 84, 89)

peer's involvement. A national syringe supply coverage by commercial pharmacies, with at least several in each city, was joined to outreach, non-profit, corporate societies, with one in each major city centres. Peers followed 'to the side' as outreach providers, until suddenly, the peers became providers of a peer-to-peer counselling service that Department of Health officials could defendably fund. From actor perspectives, pragmatism and strategies mixed in systemic connections where practices involved adjustments that drew on the cultural contingencies of material environments. From institutional perspectives, structural work on boundaries mediated change and stability. From historical perspectives, cycles of phases from community to corporation to professional, merged into events. In 1988, the 'window of opportunity' for IDU peers to enter the NEP was shaped by multiple factors. These included the differences between counselling theories, the difficulties of providing such services, and participant understandings of how a counselling interaction impacted on other social relationships. Such factors inform issues of expert authority in the later NEP contexts. However, it is not possible, in this exploration, to go further than identifying the most significant of the factors involved. The thesis illustrates how both contingent and patterned connections influenced the development of peers against professionals but into peer-professional hybridity. A hybrid stability emerged in accumulating cycles from the shaping processes of an interactive heterogeneous environment, as it partially consolidated as a settlement of differences.

Actor-network methods can analyse aspects of an erratic, discontinuous, messy, and unpredictable reality without privileging a simple and convenient but misleading account. Different social networks, each with solid reasons to distrust the corporate identity of members of the other, needed to 'exchange' not only syringes, but also goals and trust. 'Users' could not trust 'the medical profession', which could not trust 'the state apparatus of health officials', who could not work covertly against their fellow justice officials who enforced the existing drug prohibition legislation. The NEP has often been understood by participants as simply a struggle to achieve a seemingly obvious and desirable goal. Yet I have shown that the resilience and successes of the NEP could not be explained, or researched, without seeking out multiple voices, perspectives, moralities, and logics.

My descriptions and explanations have relied on initially paying close attention to the sequencing of events, alongside structural boundary dynamics, because these factors linked to my emerging analysis and provided the criteria for my ongoing sourcing of information. This ensured that the

for a usage that emphasises the tactics of actants representing and being represented in narratives. Latour demonstrates how the links between actants and agendas can be presented in stories, but where actants may become 'repositioned' and turned against the originator of their representational story. Latour specifically equates agents with actants (1999: 178-180). In general, actor-network approaches are grounded in localities of situated knowledges and interactions, which are followed closely, with a sensitivity to the effects and events that become consolidated and packaged through the circulations of references and objects. Actancy can be described as a "material semiotics" (Law, 2007:1).

case revealed itself in its quirky complexity rather than being invented as the simplest story that reduced the gaps to be filled in (Miles & Huberman, 1994: 192, 264). My use of analytical narratives entailed finding a productive way between the messy, detailed complexity of life, and the smoothness of an event as understood and strategically deployed by participants. Participants, including researchers, tend to ignore those records of the past that do not seem useful in the future. They constitute their present moments out of that evidence that cannot be avoided and out of desires yet to be achieved. This will be seen as I describe, in following chapters, how the NEP participants after 1989 reinterpreted the hybrid NEP goals from health professional to also commercial professional, and from motivation change to also the logistics of syringe circulation. In 1988, similar processes of interpreting reshaped the health professional expectations and legitimacy of the NEP. The shaping of this new environment has continued to be significant, yet so also have been the timings of critical events, and the alignment of a range of institutional and personal interests. These aspects can inform the current NEP participants about how their environment might have been different, and how a changing environment may be stabilised in more or less useful shapes.

Decisions are often explained by who makes them, within an environment of specified needs. But decisions are also influenced by constraints on time, access to information, and legitimacy. When concepts of partnership and consensus are deployed in explanations of HIV/AIDS policy, it seems useful to consider the numbers, spaces, interests, and logics that are excluded from explanations. Analyses frequently overlook how decisions are always made in actual places, with parameters and connections that are more or less difficult for different people to use. The NEP's decision-making was forced into constrained sites, where there was only room for representatives, not those being represented. The urgency and closeness made the personal qualities and positioning of representatives as influential as those wider networks of IDU, politicians, officials, and professionals being represented. These local differentials explain how particular participants were not looked for nor invited where an absence of room had been carefully arranged as tight, closed spaces by officials and professionals who wanted it that way. However, such decisions could only propose, not dispose, since the workability of proposals depended upon the configurations of resources and motivations in wider network environments.

In the following chapter I describe the founding and ending of peer group in Christchurch. New actors, without the experiences and perspectives of the NEP planners, dealt with the difficulties, opportunities and uncertainties of the initial NEP environment. In Christchurch, IDU peers became more professional within the local niche environment offered by the NEP. But their professional capabilities needed to be stably aligned with IDU needs for secrecy, and with 'ex-IDU' peer dependencies on medication and direction from treatment clinics (Valentine, 2007: 506-508, 512).

CIVDURG: A case of peer-professional disarrangements

“The true picture of the past flits by ... seized only as an image ... every image of the past that is not recognized by the present as one of its own concerns threatens to disappear irretrievably”
(*Illuminations*. Walter Benjamin, 1999: 247)

1 How do small peer-professional groups sustain themselves?

What do peer-professionals want? I described in chapter 4 how gay organisations that provided HIV/AIDS support services became established at a grassroots level, then rapidly gained a form of representation at health policy levels. Yet, after reconfiguring as a corporate NGO that 'professionalised' itself, the NZAF lost a significant degree of its direct access to policy-making. I then described in Chapter 5 how the NEP began operating from pharmacies under the general supervision of the 1988 AIDS Taskforce, a unit of the Department of Health. I went on in Chapter 6 to describe how IDU groups emerged to provide peer outreach, education, and counselling. The Christchurch Intravenous Drug User Resource Group (CIVDURG), began operations in January 1989. It might appear that once the Auckland Drug Information Outreach (ADIO) group became established as an autonomous, service-providing organisation, its urban-centred community-based model simply diffused southward. Nonetheless, a model of a simple diffusion³⁰⁷ does not adequately match the more complex story of these developments.

CIVDURG had been preceded in Christchurch by an illegal syringe supply service provided by Pollards Pharmacy from 1985 to 1987.³⁰⁸ CIVDURG operated from January 1989 to November 1994. In 1995, after an interim period of several months under the ad-hoc NECO³⁰⁹ group of IDU, the Drug Injecting Services of Canterbury (DISC) Trust began operating. The DISC Trust has provided the only peer-based outreach and needle exchange services in Christchurch since March 1995.³¹⁰

How then have some forms of organising lasted much longer than others? How have their 'internal' arrangements within organisational boundaries meshed with external connections across such boundaries? How did criminal and professional activities combine without prior models of best

307. For discussion on the quantitative modelling, statistical or conceptual, of theoretical and substantive types of 'diffusion of practices', in various contexts, particularly those involving hard to specify heterogeneous elements, see Blossfeld & Rohwer (2002: 178-180, 255-264). In general, these authors suggest a high degree of caution in an attempt to predict substantive events, due to the high degree of ambiguity of the substantive areas being studied, and unavoidably arbitrary research decisions needed to be made, overtly or covertly, in even the best of research designs.

308. Pollards Pharmacy joined the NEP in May 1988. See Mainline (2003b) for details of this story.

309. NECO stood for Needle Exchange Consumer Organisation. It was formed directly from IDU networks in response to the threatened loss of peer needle exchange services in Christchurch.

310. The material in this chapter has been selected from CIVDURG minutes, logbooks and other documents; from Department of Health, Public Health Commission, and Ministry of Health reviews of the NEP; supplemented by interviews with participants. I also draw on my own experience as a CIVDURG Trustee from 1989 to 1992, and briefly in 1995 to wind up the Trust.

practice and of appropriate aspirations?

Four configurations of networks contributed to the founding and stabilising of CIVDURG. The first consisted of the local New Zealand AIDS Foundation (NZAF) networks and resources. The second was the Department of Health officialdom, especially the AIDS TaskForce co-ordinator in Wellington, the Christchurch Medical Officer of Health, and the Christchurch District Advisory Pharmacist. The third assemblage of connections consisted of the local IDU networks. The fourth was centred on the personal networks and the intensely motivated aspirations of two people, then domestic partners, who had adequate motivation, organising skills,³¹¹ and active IDU connections.

When the NZAF became aware of the need to rapidly establish a peer outreach and after-hours needle exchange group in Christchurch, they looked for potential founders. In February 1988, CIVDURG's founder met Rodger Wright at a drug treatment centre while Wright was carrying out a survey of the knowledge held by IDU about HIV/AIDS.³¹² Following this meeting the founder and her partner left their voluntary work with the Christchurch Unemployed Rights Collective and became involved in the Christchurch Branch of the I.V. League, which had been active since 1985. They then took part in the July 1988 training intake for NZAF volunteers. Local NZAF personnel encouraged them to negotiate a contract with the AIDS TaskForce. Any others attempting to start a competing peer group in Christchurch would not have benefited from such supportive, wide-ranging connections.

In August 1988, according to the founders' account, the IV League activities and organisation in Christchurch ended.³¹³ However, they considered that more could be achieved for Christchurch IDU, so began organising a local Outreach Group (CIVDURG, 1991b). In December 1988, they received confirmation that they would become personally contracted to the AIDS TaskForce to found a peer group that would become a legal entity and hold any future contracts.³¹⁴

CIVDURG was registered as an Incorporated Charitable Trust in March 1989 (CIVDURG, 1991b), with this couple as its sole employees. In this process of incorporation they detached themselves from their previous IV League associations. Wright had co-founded the IV League and represented IDU to Parliamentary Committees (Wright, 1990). He was the key IV League participant in Christchurch, yet was neither an employee nor a trustee of CIVDURG when it began.

Groups such as CIVDURG have been described as following in the model of the Auckland Drug Information and Outreach (ADIO) model.³¹⁵ This ADIO model could describe the groups in the

311. One had managed a hostel in the UK, and also had brief experience of video and script production work (CIVDURG, 1991b).

312. This survey was part of Stephen Lungley's 'Baseline Study' (Lungley, 1988). See Robinson (1990: 3).

313. I have not found any description by Rodger Wright of these months. Robinson notes in his review of the peer groups (1990: 4, 13), that the Dunedin peer group wanted to develop a drug treatment consumer group similar to the IV League.

314. This was the pattern with the initial five groups (Robinson, 1990: 6, 16).

five major cities.³¹⁶ The AIDS TaskForce contracted such privately incorporated, autonomous groups to provide the outreach and after-hours services for the NEP. The initial intent of this isolation was to: “assess local needs, reflect these needs in the services offered, and gain support from health professionals in their region” (Robinson 1990: 6). This stand-alone form of organisation reduced the wider costs and accountabilities of governance, for instance in: “the possible diluting effect on funds if the existing total amount is distributed among all area health boards. Currently services are ... provided in five board areas” (Robinson 1990: 19).

The TaskForce began contract negotiations with several other prospective peer groups, for instance one in New Plymouth. This indicates that there was an initial policy of increasing the numbers of the isolated peer groups. However, the TaskForce could only afford to sign a contract with the Dunedin peer group (DIVO), by drawing on emergency funds (Norrie, 1989). The TaskForce could not afford to contract more groups, especially after the funding for AIDS was reduced in 1989 (Fithian, 1989).

CIVDURG copied ADIO as a structural model, but also resisted many of ADIO's goals and methods, while drawing on different local network resources. ADIO had been started by people such as Mary Foley, Robert Kemp, and Erin Watts (2004, pers. com.) who worked professionally at the Auckland Methadone Clinic. Similarly, the Christchurch Alcohol and Drug (A&D) services had a strong, supportive connection with CIVDURG. By contrast, CIVDURG's two employees were clients of the A&D services, received a methadone supply,³¹⁷ and were not employed as qualified therapists. The two employees distrusted the more professional organisational practices, aspirations, and personalities they perceived as characterising ADIO (Co-ordinator 1989d).³¹⁸

The Co-ordinator and her partner disliked being advised by the ADIO co-ordinator on how to organise their Trust Board. Kemp, the ADIO Co-ordinator: “... immediately started telling us who to get on the Trust but although some of our names might not be as well known as ADIO's equivalents they are all very committed to actually doing something, not figureheads. Besides, we can always ask more [trustees]” according to the CIVDURG Co-ordinator (Co-ordinator, 1989d).³¹⁹ The CIVDURG Co-ordinator prioritised the enrolment of supportive contacts in her selection of Trustees. Rather than looking for well-known names in the field, she considered that: “we have a

315. See Robinson (1990: 3), Foley (1989 as cited by Co-ordinator, 1989d).

316. Auckland, Palmerston North, Wellington, Christchurch and Dunedin. See Chapter 6 for a more detailed description of different tendencies over regional and urban aspects of NEP policy.

317. Robinson notes: “Only one centre adopted the view of those working in the drug treatment and rehabilitation field. This centre employed staff who had been “clean” for several years. The paid staff in the other four centres are all either currently on the methadone programme, or have had recent drug using experience” (1990: 15, 23).

318. Despite ADIO's stated intention of eventually becoming a user-run operation (NSERCM, 1989).

319. Later events showed that starting with high profile Trustees and not driving them away was more important than the CIVDURG co-ordinator (1989b, c, d, e.; 1990a, b) had realised. The CIVDURG Logbook covering 1989 shows several hopeful comments about prospective professional trustees, yet none were prepared to be associated with the CIVDURG Trust. DIVO administrators were well aware that the Department of Health officials considered professional management capabilities to be crucial for retaining funding (Coville, 1993).

good mix of Trustees - users, ex-users, social workers, Ian Smith from the NZAF, and an ex-addict Doctor (Who is now a Dr, at the A & D centre!), and our epileptic comic artist" (Co-ordinator, 1989d). CIVDURG's founders were "a bit suspicious of people with university degrees who become professional drug-abusiologists" (Co-ordinator, 1989d).³²⁰

The CIVDURG founders advocated for better access for IDU to methadone services (Robinson, 1990: 13), but did not attempt to copy ADIO's project of setting up an alternative methadone clinic on ADIO premises.³²¹ CIVDURG's founders were also suspicious of an 'empire building', pre-arranged, national structural model for the NEP's peer group development. They were sceptical because: "... it looks as though Roberts [³²²] purporting to work out a national policy on IV drug use in NZ when he has already worked out exactly what he wants to do as in the report!" (Co-ordinator, 1989d.). They were:

a bit suspicious that ADIO are basically trying to set up another methadone clinic. In ChCh at least the existing Alcohol and Drug clinic could introduce exactly the same basic scheme if they were given more money and resources ... Reports [³²³] like ADIO's seem geared more to the needs of the service providers rather than the addicts themselves. (Co-ordinator, 1989d)

The CIVDURG founders preferred a model of building from the grassroots up and extending a network of alliances. This hands-on approach involved getting "out of the office, contacting users, doing workshops abd [sic] getting to Dunedin to help them set up their own IVDU group - hopefully more along the lines of the IV Union and CIVDURG than ADIO" (Co-ordinator, 1989d).

Kemp in turn seems to have placed little confidence in CIVDURG's Co-ordinator, who recorded that: "all Robert said about us was that he hoped we survived as a couple of groups had already folded and if we did too it might mean the end of funding!" (Co-ordinator, 1989d).³²⁴ However, on a visit to Christchurch, Kemp asked the co-ordinator of the Christchurch Branch of the New Zealand Prostitutes Collective (NZPC):

to do work with IVDUs apart from Prostitutes who use, she wasn't interested but it seems to me that he's not taking us very seriously, he behaved as though he thought we were a bunch of incompetents which isn't the message we're recieving [sic] from everyone else who actually knows us!
(Co-ordinator, 1989d)

CIVDURG was certainly modelled on ADIO and assisted by ADIO. Yet it was shaped more by the local Christchurch environment of 'dense' long-term networks of health professionals which had been recently added to by personnel from AIDS Service Organisations.³²⁵ From a personal career perspective, the professionalism and scale of ADIO's capabilities created dangerous comparisons

320. See also NEXUS (1990e, f), NEXUS (1990a, b, c, d), NEXUS (1992), NEXUS (1993a, b).

321. See Robinson (1990: 14), NSERCM (1989).

322. Robert Kemp, then ADIO co-ordinator.

323. "... a massive document (a feasibility study) about wide-spread, easy-access low dose methadone maintenance proposed mainly by Mary Foley" (Co-ordinator, 1989d).

324. Intriguingly, I found no records or other referents to any other groups collapsing, although at least one had a very dynamic Trust Boards with high turnover. Kemp may have been referring to non-IDU groups.

325. See Brown, (1999), Robinson, (1990: 13, 19, 23), Co-ordinator (1989d).

that threatened both the IDU norms and the employment aspirations of CIVDURG's founders. The founders had been extremely poor, with few prospects for conventional employment.³²⁶ Prior to founding CIVDURG they were nominally self-employed (Robinson, 1990: 16, 18). CIVDURG offered an uncertain and indefinite type of job security when it opened its doors to the injecting public on January.

Picture 2: CIVDURG seen from the street at dusk

(Personal records. 1989-early 1990s)



(The stairway leads up to the office and counter. We would come down if anyone with mobility problems asked us to, but such arrangements were not adequate.)

CIVDURG faced four specific local difficulties. First, the lease of the initial premises was opposed by some neighbouring businesses for supposedly attracting undesirables into a tourist area (Matterson, 1988). Second, CIVDURG's peer organisers experienced a general stand-off attitude by 'self-help', 'higher power' therapy and abstinence-oriented organisations of ex-IDU.³²⁷ Third, there were initial difficulties with the different perspectives and expectations of the District Area

326. None in their social circles had been recently employed, except in Government work schemes (Robinson 1990: 18).

327. However, there were greater connections and fewer problems with professionally qualified treatment professionals, to whom requests for referrals were often made. A&D staff sat on CIVDURG's Board until 1990.

Pharmacist, who was employed by the Department of Health to monitor pharmacies. Fourth, there was also a conflict with a different peer group of ex-IDU women who were not 'higher power' oriented but took an abstinence stance on drug use.³²⁸

These problems were overcome or ameliorated through the resources and trust that was produced from the numbers and strategic positioning of the local connections. Shortly after CIVDURG was founded in 1989, Ian Smith, the Regional Training Co-ordinator of the NZAF, became the Chairperson of the CIVDURG Trust, until resigning in 1990 to undertake HIV/AIDS organising work in Thailand.³²⁹ Smith's liaison/Chair role on the CIVDURG Trust Board was taken over by Marie Glenys, a qualified and influential NZAF counsellor (New Zealand AIDS Foundation, 1988: 4). Several other CIVDURG trustees were professionals, one working as an established A&D counsellor, another as a GP. Nonetheless, the connections with IDU networks were essential, and familiarity between peers and clients is often apparent in comments in CIVDURG's day-books. Yet these connections were not particularly useful in organising the group.³³⁰

The most productive connections drew on a separate network that overlapped with IDU networks. The Co-ordinator and partner, the Trust Secretary, two Trustees, and two core volunteers, had been meeting every week for several years as part of an anarchist-inclined group that ran role-playing games.³³¹ The two core volunteers from this group who were not initial trustees joined the Board within a year. The Co-ordinator's partner, a historian who ran a role-playing game, was employed by the CIVDURG Trust Board as an outreach co-ordinator. The Co-ordinator, who had prior managerial experience, was also employed by the Board as the office manager.³³²

The Co-ordinator was on methadone maintenance treatment (Robinson, 1990: 15, 23; Lewis, 1989). This would not normally be appropriate to specify. However, there are three justifications. First, since the NEP is significant, the crucial influences on the key actors involved in the developments need to be included in the analysis. Second, the key actors chose to position

328. This group was not involved in providing needle exchange services, but did provide counselling for motivational change of women IDU. The founding CIVDURG Chair of the Board also belonged to this group, until conflicts of interest led her to resign her CIVDURG Trusteeship.

329. See CIVDURG (1990b); Smith (2004) pers. com.

330. Several IDU volunteered for short periods before being asked to leave due to petty theft or drug using or selling at work. This was a manageable problem. See Robinson (1990: 15-16, 23).

331. Advanced Dungeons and Dragons, Call of C'thulhu, Traveller, Stormbringer, and Flashing Blades attracted our attention. Some of this group were members of the Christchurch Unemployed Rights Collective (CURC). There was little work at that time in Christchurch, apart from temporary government schemes. Many people had time on their hands, and the social activities of some followed drug and political routes, that is immediate or deferred gratification, rather than solid mid-future prospects of family and employment. It was a pointlessly happy time. The country had been invaded from within, the previous social accountabilities were becoming only memories, but no-one had yet come to round up the young single criminals, and the disruption to centralised state sector approaches had created difficulties for the police. Anarchists were perplexed, but many felt it their duty to enjoy themselves no matter what the risks. One friend blew himself up outside the Wanganui Computer Centre in an act of political martyrdom. I volunteered for army training, learning how to fire howitzers. Others preferred drugs. With the government in the throes of neo-liberal ecstasy, everything made sense, for any alternative was defined as 'non-sense'.

332. All these players used illicit drugs, about half injecting opiates, the rest preferring marijuana and psychedelics. All

themselves in a public gaze, and be rewarded for their activities, which they themselves represented as being of major public significance. Accordingly, their independence, or lack of independence, is of analytical concern. Third, the CIVDURG co-ordinator strategised her positioning between being on treatment and running a needle exchange in ways that initially benefited the empowerment and safety of Christchurch IDU, yet eventually jeopardised these goals. The power the co-ordinator exercised in this situation requires paying attention to her dependency on A&D professionals. Fourth, anonymity and confidentiality has already been thoroughly breached by her treatment service providers in combination with the District Advisory Pharmacist, as well as being published in Robinson's NEP review of 1990. Consequently, the co-ordinator's methadone treatment details entered records accessible by the AIDS TaskForce officials. Significant aspects of CIVDURG cannot be understood without knowing this important reason why its manager needed to be particularly protective of organisational information, and particularly personal in her selection of Trustees. There were IDU types of secrets to be protected. I have taken care to only present the minimum personal information needed for this analysis.

In February, 1990, the co-ordinator became accepted onto an 'Addiction Studies' course (CIVDURG, 1991b). This course was the minimum requirement for becoming qualified as an Alcohol and Drug Counsellor in New Zealand. The professional counselling training was most likely embarked on to be combined with peer outreach activities, though this had never been formally ratified as a Trust goal. This professional career aspiration seems a more individual variation on the ADIO proposals for improved models for methadone services. However, the CIVDURG Co-ordinator's tactic required fewer resources, support networks, and planning because, unlike a new model for methadone treatment clinics, it did not compete for territory with existing professional institutions.

In earlier chapters I described how needs that were strongly IDU peer and significantly professional emerged from a reconfiguration of existing institutions due to HIV/AIDS. These needs created a niche environment that also involved both peer and professional connections. These needs and environments, accordingly, linked peers to the possibilities of entering a conventional career strategy. The connection had been constructed for abstinent ex-peers and was supposedly closed to IDU peers. Yet it appeared to open up due to the influence of the peer-professional logics and practices of the NEP. The normalisation, not of drugs, but of drug users, was making increasing sense to some treatment professionals. This attitude shift in some treatment specialists was helped by health networks, political goals, and occupational possibilities becoming re-articulated through exposure to the peer-professional model, which seemed manageable when

consumed alcohol enthusiastically, and most smoked tobacco. At the time, several of the opiate injectors were recreational users, developing habits during 'poppy season', then withdrawing and using regularly, but not dependently, over the rest of the year.

supervised. However, as the co-ordinator's personal activities moved away from the sheltered niche of combined peer and professional activities, towards the conventional professional types of activities, it became more difficult to hold the IDU and professional relationships in alignment.

While studying for the addiction counselling qualification, the co-ordinator began filing case notes on some clients. The Trust Board had insisted that the co-ordinator receive supervision (CIVDURG, 1991a). However, whether that supervision had covered the contents and procedures of taking case notes on NEP clients was later impossible for the Trustees to ascertain. In December 1994, client case notes were found in CIVDURG's files, causing ethical and legal problems for the Trust Board and the interim NECO management collective. The Board had never held supervisory control over these activities, nor is recorded as having delegated such control to the co-ordinator's treatment providers or to the Central Institute of Technology (CIT) which provided and oversaw the counselling training. Taking case notes may have been represented to the Department of Health as peer outreach work, but IDU peers themselves were in no doubt that such actions went well beyond the parameters and ethos of IDU peer behaviour and motives.

The case notes created problems for the Board because the practice offended against community values and undermined requirements for informed consent when recording personal information. All knowledge from the period when the case notes were created had disappeared, or was not trusted. The Board could not know what the participants had expected at the time, or later, regarding the use such notes might be put to. There was no professional system of extended collegiate accountability to assist in transferring information in a trustworthy way between the two eras of management. Clumsy inquiries would have generated rumours that would have harmed the reputation of the exchange even further among IDU.³³³ The later IDU peer-professionals considered such note-taking to be completely unacceptable³³⁴ from both peer and professional perspectives.

IDU do not generally write about each other, because it would seem intrusive and only conceivably intended for harmful purposes. Members of an IDU network would become dependent on the writer's discretion and on the uncertain circulation of such writings. IDU do not usually record anything that might harm them later. It is an oral culture. Some IDU might accept that an unknown researcher could safely record personal information, since such researchers would only know what IDU tell them. But a peer would know far more harmful information, which gives IDU more cause to avoid becoming dependent on the motivations and competencies involved in such writings. The notes breached IDU norms of an equal and oral culture. Moreover, the note-taking breached professional norms of clear chains of supervision and accountability.

333. I could not write about this if ten years had not passed, and if the writing did not contain reasons for readers to accept that such situations could never happen again.

334. When CIVDURG collapsed these case notes were found and handed over to the Community Law Centre for supervised destruction. IDU working at the exchange had no idea of their content or legal status and found them unacceptable when they learnt of them.

CIVDURG had not been able to pay its two full-time employees from the income from selling syringes, nor from its AIDS TaskForce funding after the initial ‘start-up’ contract period ended.³³⁵ It had relied instead on extra income from agencies such as the Community Organisation Grants Scheme (COGS)³³⁶ and the Lotteries Board.³³⁷ When funding pressures escalated after 1989, the AIDS TaskForce responded to requests for funding increases with the suggestion that one paid position should be disestablished. In 1991, the co-ordinator became the sole paid position, required to achieve administrative, educational, networking, sales, and outreach goals. This workload forced the co-ordinator to increasingly depend on the commitment and expertise of volunteers.³³⁸ However, as later events illustrated, many peer and professional volunteers came to consider the co-ordinator incapable of working effectively with others outside of drug-using types of activities. Moreover, these volunteers usually held additional accountabilities as Trustees. Their trustee accountabilities conflicted with the personal link with the co-ordinator that had first drawn them onto the Board.

The response of the peer Trustees on the Board to such difficulties can be divided into three tendencies. There were the co-ordinator loyalists who wanted the Trustees and volunteers to be more supportive of her personally in order to continue the collective goals of the organisation. There was a ‘make the co-ordinator constitutionally accountable’ bloc which accepted the logics of a corporate infrastructure and accountabilities despite their drug-using and anarchist sympathies. Finally there was a ‘hope things can be gradually improved without major changes’ bloc where motives and the degree of future planning were not clearly stated in discussions.³³⁹ All these perspectives valued stability and productivity, but in increasingly antagonistic ways.

In actual conflicts, the loyalists and the gradualists allied more often than not, while the accountability bloc trustees experienced increasing reasons to resign, rather than remain accountable for the continuing management problems. Such problems not only included internal issues of competency, but also external issues of image and reputation. The internal issues included the specification of employee rights and accountabilities which had never been formalised.³⁴⁰ The external issues included two criminal convictions during this period. In 1990, the Treasurer was

335. The initial contract was with two individuals who founded CIVDURG, not with its Trust Board, although the later contracts between the AIDS Foundation and the Trust Board were never referred to at the time as any different from the original contract. This matter did not seem relevant to the Trustees until several years later, when Trustees were concerned to establish what the historic salaries had been, to provide arguments for extra funding for non-budgeted services, and to evaluate the employment needs of the Trust. However, by that time there was no surviving record of the original contract, and other problems seemed more urgent.

336. COGS and the Lotteries Board were community grants organisations that distributed funds from the Government.

337. Robinson notes: “Both ADIO and CIVDURG have received additional grants from other sources to repay overdrafts. For example current [sic] CIVDURG expenditure of \$70, 680 per annum is considerably greater than the Task-force grant of \$54,000 per annum” (1990: 18).

338. This was a general problem according to Robinson (1990: 16).

339. DIVO minutes record similar conflicts until 1992, as did the IV Union in 1989.

340. It was difficult and legally risky to fire the co-ordinator, since no standards existed to compare her performance against. When the co-ordinator started bringing her lawyer to Board meetings, any remaining internal trust vanished.

convicted of manufacturing methamphetamine, and in 1992, the co-ordinator was convicted of stabbing a victim over an associate's debt for an illegal firearm (Christchurch Press, 1992: 5). After the assault conviction, the co-ordinator's goal of becoming qualified as a professional drug counsellor appears to have no longer been openly supported by her course tutors.

These incidents risked opening up the discretely private world of the Trust to scrutiny from outside. In both cases the reputation of CIVDURG, the NEP, and the Trustees was preserved only by the NEP link not being reported in the media. These incidents created difficulties for the Board's supportive stance on employing IDU. In March, 1990, an amended CIVDURG Constitution required that the Board: "acts as an advocate for IVDUs when issues pertaining to intravenous drug use arise" (CIVDURG, 1990a). In October, the AIDS TaskForce asked the Board to state its policies on drug-using by employees. The Board responded that drug use was ignored, as a private matter, unless it impacted on work performance (CIVDURG, 1990a).

Although an employee's work performance could potentially be monitored and managed by the Trust, convictions for crimes created organisational hazards that were difficult to manage, and could not be prepared for in advance. Any publicised incidents of assaults and drug manufacturing seemed likely to decrease CIVDURG's professional reputation and longer-term capabilities. Furthermore, the work performance aspects of substance use³⁴¹ could not be managed effectively if the Trustees felt obligated to protect such employees. Yet, CIVDURG's problems did not cause the major changes to the NEP that had concerned Kemp in 1989. This was because Kemp and those Department of Health officials who were formally accountable for the NEP refused to receive the requests for help from several CIVDURG Trustees.³⁴²

From a perspective outside the Trust, protocols around the formal autonomy of CIVDURG and lack of any specified due process meant that complaints by individuals, even Trustees and officeholders, could readily be ignored. I surmise that these Department officials also knew that if the complainants had wished for media publicity, this would already have been generated, and the situation would be apparent to all. From an insider perspective, the co-ordinator's peer status helped to deflect any expectations of her being accountable as an employee and as a Trustee for long-term organisational stability. IDU do not expect other IDU to be accountable over long periods. The peer trustees had reasons to feel uncertain in the middle of an inherently unstable situation of conflicting values. The Department officials had reasons to not acknowledge any problem. They could not intervene in a private corporation except through the terms of their funding contracts. These contracts were supposedly secret, and a conflict which triggered their

341. I use the term 'substance' to refer to licit drugs such as alcohol and nicotine as well as illicit drugs.

342. Complaints by the Treasurer, which I witnessed and supported as Secretary, were not responded to by the Department of Health officials. In 1992, Kemp was reported by the co-ordinator as assuring her that: "... the Department of Health Wgtn didn't give much credence" (Co-ordinator, 1992b: 1) to Trustee complaints to Christine Nottingham, who was the first point of contact between the NEP and officialdom.

becoming public knowledge would escalate existing problems with other peer groups. Nor was the political timing suited for the supporters of the NEP to wish to bring problems of institutional unaccountability to the attention of politicians and unfriendly officials, for instance in Justice or Treasury sectors. It seemed possible, at any time in the early and mid-1990s, for the peer groups to be abruptly reconfigured.³⁴³ Nonetheless, the rationale for the Board to assert control involved the damage done to the longer-term prospects of IDU empowerment. In covering up the co-ordinator's immediate problems, the Board invited further problems. From the IDU peer Trustee perspective held by a minority on the Board, the on-going incidents made it more difficult for later Boards to justify employing IDU managers.

This environment, contributed to by Department of Health officials as well as by IDU, acted as a 'separating mechanism' for peer-professional hybridity. The logics and expectations formed lines of division that combined with wider institutional contours to create increasing difficulties for professionalising projects. The interplay of officialdom, health professional service aspirations, IDU cultural norms, and the need to guarantee an IDU-friendly syringe supply provided incentives for peer-professionals to leave CIVDURG's Trust Board. On the other hand, a single dominant peer-professional had incentives to remain on the Board and as an employee, through tactics of separation from the IDU network ethos and ethics towards those of full professionalism. Yet the only way to carry out work of professional quality in this field was through the peer groups and there was only one in each city.

From many peer perspectives, the co-ordinator's assault conviction was, in itself, of minor significance, although the circumstances gave cause for alarm.³⁴⁴ Nonetheless, the assault conviction had disturbing peer-professional connotations. Some IDU had concluded that the NEP connection had influenced the co-ordinator's access to the most desired level of opiate maintenance treatment. The assault and conviction would have altered any DSM IV diagnosis in terms of any social and legal problems related to drug misuse and to the requirements for continuing maintenance treatment, as would be known to those on the long waiting list for treatment. This situation jeopardised the professional reputation of the A&D Services, as well as the moral understandings of peer 'equivalence' held by many IDU. However, CIVDURG's Board treated such consequences as 'private' business rather than as part of the Board's accountability to protect the reputation and capabilities of the organisation.³⁴⁵

343. Kemp considered that "Christine [Nottingham] & another (new) woman would be the ones important [sic] regarding proposed changes to the structure of IDU Outreach" (Co-ordinator, 1992b: 1).

344. From a different peer perspectives, the idea that the assault could easily have been avoided was more important, because no IDU appreciates their affairs being probed into by police due to avoidable behaviour by someone who should have more self-control in broad daylight on a public street. The methamphetamine manufacturing conviction of the Treasurer was not considered significant at all, apart from in the formal sense. This period was before the moral and media panic over the use of 'P' (strong smokable methamphetamine), which became a staple of the New Zealand drug market in the late 1990s. This was the first conviction for manufacturing methamphetamine in the Canterbury region. The recipe was sourced from the internet, and no gang associations were involved.

345. Several peer-professionals did not accept the co-ordinator's actions, but were outvoted.

The assault conviction also influenced the addiction counselling training. When other students and the Course Executive had learnt in 1990 that a morphine-dependent student might become qualified to practice (Co-ordinator, 1991), a concerted attack was mounted on the co-ordinator's enrolment. Local tutors and supervisors responded with a strong defence. An overseas expert offered cautious approval for substance-using counsellors, provided a close supervisory structure was maintained (Wodak, 1991; Parrish, 1991). The issue helped to open up such courses to those not ideologically dedicated to abstinence, yet who could be trusted to uphold the quality and reliability of the qualification, and accordingly, gain access as proponents of harm reduction to professional forums for treatment specialists. But the assault conviction seemed likely to reverse such gains and to exclude recreational or dependent substance users from becoming qualified practitioners. Such damage to the prospects of harm reduction angered some peer-professionals on CIVDURG's Trust Board, who wished to minimise any further damage.

The last of the CIVDURG Trust's effective chairpersons had qualified as a health professional and worked at the A&D clinic. This extremely professional peer also assisted the members of the Prostitutes Collective in their street outreach at night (Reed, 2004. pers. com.). In late 1992, after I had left CIVDURG, this chairman stated that either the co-ordinator or he must resign. The Board was loyal to the co-ordinator, and the chairman left.³⁴⁶ There followed a period of diminishing professionalism and increasing control of the Trust by a smaller number of peers. These peers seemed, on average,³⁴⁷ loyal more to each other than to the professional goals of the trust, or to the NEP, or to acting as a voice for IDU. This loyalty created a problem in terms of professional concerns for maintaining public trust and accountability, which in a peer-professional situation, has seemed better if continually increased, not merely maintained. However, CIVDURG's situation also accords with conventional professional interests in minimising or deferring external scrutiny.

After the Chairperson had been induced to leave in late-1992, the co-ordinator recruited an accountant who was surprisingly supportive, for a non-IDU who did not work in the drug treatment area.³⁴⁸ CIVDURG began to regain financial stability, but the accountant, being terminally ill with cancer, died before managing to improve the core sustainability of the organisational structure. Only the ability to produce audited accounts and the immediate management of cash-flow were improved. By mid-1993 there were no health professionals, no fund-raising specialists, and no independent peer-professionals left on the Board, according to the few minutes of meetings.³⁴⁹ Nor did any strategic plan emerge to address these deficiencies and extend services.

346. There are no minutes of this crucial meeting. The report is anecdotal, from reliable sources. The chairman did not appear in any later minutes. The authority of the co-ordinator had become unchecked. Resignations over the following months left the Trust Board gutted by mid-1993.

347. In arriving at this generalisation I considered the Trust Board decisions, as minuted, to provide an average of the peer-professional attitudes in terms of being more peer tending or more professional tending.

348. The link to this accountant may have been the co-ordinators membership with him in a local book society.

349. Most meetings over that period are recorded as being cancelled due to lack of a quorum. Letters and notices were circulated requesting volunteer workers and prospective Trustees to attend planned meetings.

During the period of organisational disintegration that I have described, no alternative models for peer outreach were proposed. I found no description of IV League proposals for Christchurch, from when ADIO was founded and received state agency approvals and contracts, to the stage of CIVDURG's founding. Despite publicly supporting CIVDURG, Wright had felt personally betrayed at being excluded from the resources of CIVDURG (Reed, 2004, pers. com.). Indications of conflict between Wright and the CIVDURG co-ordinators continued for eight months, until a negotiated compromise led to Wright becoming licensed in June and joining the Board in August. However, Wright did not then take any significant part in CIVDURG activities. He worked instead along different connections that did not depend on CIVDURG and could not be compromised.³⁵⁰ Until he died in December, 1993, Wright dedicated himself to educational work in schools, taking full advantage of the rare opportunity to work within the education system on a health syllabus for AIDS education.

During this period from 1989 to 1995 the NZAF and New Zealand Prostitutes Collective developed an increasingly coherent working alliance. By contrast, CIVDURG became increasingly defensive and isolated from the regional AIDS service organisation networks, according to evaluations of the NEP in 1994 (Auerbach, 1994b, 1994c, 1994d). The Prostitutes Collective opened a small needle exchange where not only sex-workers, but also IDU who wished to avoid CIVDURG could access syringes. However, the provision of NEP services in NZPC premises became part of national protocol that developed in the early 1990s. Such protocols were approved at a policy level, and only coincidentally ameliorated the differences between sex worker and IDU representation in Christchurch. CIVDURG'S isolation due to its interplay of personal and structural problems escaped official notice.

2 Evaluating a private site of peer-professional hybridity

I have described how the private nature of CIVDURG, combined with its contractual funding structure, led to some evasion of accountability and increasing capture by a strategically-positioned employee. From an external perspective, CIVDURG was an autonomous peer-based exchange in a contractual relationship with a state agency. However, CIVDURG was subject to the same NEP regulations that controlled the pharmacy exchanges. Regular surveillance and evaluation by state agencies was potentially provided by the local Medical Officers of Health and District Area Pharmacists, as well as through the reporting provisions written into CIVDURG's funding contracts. Nonetheless, Pollards Pharmacy had sold syringes illegally for several years, in plain sight of the District Area Pharmacist, and continued to sell single syringes illegally.³⁵¹ This

350. The minimising of Wright's previous efforts, and his unrecognised work on the National Council of AIDS, as well as his public speaking as an IDU person with AIDS, especially in youth education through school visits, were reasons for the DISC Trust to rename the exchange premises 'The Rodger Wright Centre'.

suggests that much might, and did, evade such a regulatory regime.

CIVDURG also caused surveillance and evaluation problems for the District Area Pharmacist. The part-time peer workers had to become registered as 'suitable' by the District Area Pharmacist.³⁵² However, he had no way of knowing whether the applicant was suitable or not, beyond checking for a minimal knowledge of the hazards of sharing syringes and the NEP Regulations. The quality of sympathetic engagement with illicit drug users, which the District Area Pharmacist was employed to detect, deter, and report in pharmacists, was exactly that required for peer needle exchanges. He had no way of telling if a prospective syringe seller was likely to use or sell drugs on the premises. Instead, he relied on recommendations from CIVDURG management and the A&D centre (Lewis, 1989).

The necessity to engage with IDU required the District Area Pharmacist to depend upon the surveillance provided by A&D treatment professionals, yet also upon CIVDURG's peer expertise. The District Area Pharmacist could not arrive unannounced to inspect the peer exchange, as he could at pharmacies. The exchange was closed during scheduled visits from officials, so that IDU clients were not observed. The District Area Pharmacist stated that the : "policing of who sells N/S packs at CIVDURG is impossible" (Lewis, 1989).

The small, solid core of part-time volunteer workers that emerged over the first year were skilled, acceptable to clients, reliable, and discreet. The Trust then requested three more part-time workers to be registered, including Rodger Wright.³⁵³ This request was made because greater numbers reduced the problems in scheduling shifts and carrying out outreach activities. Notwithstanding, the District Advisory Pharmacist complained to the AIDS TaskForce co-ordinator that too many peers had already been registered, citing the support of the Medical Officer of Health (Lewis, 1989). However, CIVDURG was a shop-front as well as a peer outreach centre as well as a professional³⁵⁴ contact and referral centre.

In 1989, CIVDURG was a shop with a single product, as illustrated below. Also illustrated is the effective equivalence of the hands on either side of syringes, as the exchange is made. One set of hands could not be closely monitored without the other being included.

351. Mr. Pollard had highlighted the inaction of professional and state authorities by showing how easy it was to reduce HIV transmission, while also covering his costs. Mr. Pollard continued selling syringes as part of the new NEP, but was not popular with the District Advisory Pharmacist, who informed the AIDS Taskforce that Mr. Pollard was selling off old stock rather than the regulation syringe brand. Mr. Pollard was also accused of selling singles, rather than the regulation ten-pack.

352. See, for example my registration in Appendix 2.

353. Wright was the most experienced peer educator in the country, having worked with politicians and IDU from 1985.

354. Robinson notes aspects of non-professionalism, for instance that: "Training usually consists of sitting in on a session with other volunteers" (1990: 16), yet also of professionalism: "... a bewildering variety of potential tasks that staff could be involved with, each requiring differing skills and experience. For example, the initial step of setting up a service required facilitation skills while the next stage of networking with other agencies and developing services was a community work task. Running the centre requires administrative skills and the outreach work, including preparation of material, is an educator's job" (1990: 16).

Picture 3: The act of exchange

(CIVDURG Archives)



CIVDURG's funding contract was negotiated yearly and required quarterly reports. The work requirements included long-term strategy, medium-term administration as well as short-term shop management aspects. Moreover, peer employees had not competed for their jobs, they had not been selected for their skills in office management, nor for their robust psychological disposition. In consequence, extra staff seemed required to help, but according to the NEP Regulations, such staff needed to be approved through a registration process.³⁵⁵

Nevertheless, the Department of Health and the Medical Officer of Health acted as if they considered the outreach work and the off-site education work to have a specific limit, beyond which the NEP activities were not to be considered valid. Yet this limit seemed of their own creation, since in outreach activities, more workers are more effective, managerial problems aside. The official attitude, as enforced by these Department of Health officials, was that low numbers were more than adequate. The peer members of CIVDURG were extremely upset that such

355. Nobody knew in the initial years how much work was involved in this new peer-professional environment. It was not like a standard pharmacy, where needle exchange sales were easily added to the standard daily repertoires. Instead, new systems appropriate for a peer exchange and for a volunteer work force had to be developed and constantly modified. New standards of appropriate and inappropriate client interactions had to be worked out. A constant flow of information from IDU networks was required to indicate how the services and personnel were perceived, and what unmet needs might exist. CIVDURG peer-professionals needed to obtain information, evaluate it, pass some of it on to state authorities, while ensuring that CIVDURG was not perceived by IDU clients as helping police.

decisions seemed made by low-level functionaries, influenced by ignorance and perhaps prejudice, in the absence of clear and transparent policy.

The District Area Pharmacist's logic and restraints stifled the provision of peer outreach through the networks of volunteers. His activities also promoted an assumption that peer outreach connections were not valid. In 1990, the terms of reference for an evaluation of the peer groups did not include any reference to or description of outreach, despite the groups often being labelled as 'outreach groups' (Kerse, 1990). Between 1991 and 1993 this perspective was strengthened by the Department first indicating its opposition to providing sufficient funding for a dedicated outreach co-ordinator, then eventually refusing such funding.

Nonetheless, CIVDURG personnel had found outreach prohibitively difficult outside of their personal networks. New Zealand did not have street drug 'scenes'. What outreach work remained seemed to require access to situations of injecting in private residences. Only people with prior invitations could carry out such outreach. Accordingly, efforts had shifted towards providing educational written material with an outreach component to the IDU who had been attracted to the central city exchange site. It was hoped such material would circulate around the local network connections of IDU.

A 'shop-front' was easy to make into a 'instrument' for educating and communicating with IDU. Just as the NEP's funding streams mixed user-pays with state contracts, so also were the senses of ownership, images, and resources of the NEP premises mixed between private and collective organising. Management could legitimately minimise personnel, since achieving reliable standards with larger numbers entailed increased supervisory costs. This conventional shop model treated part-time staff as interchangeable, the only constraint being the difficulty of recruiting replacements if current staff left. Unless specifically countered, the commercial and privatising logics inherent in the funding contracts impelled CIVDURG towards minimising labour costs, and away from employing or supervising larger numbers from marginalised communities. This problem increased after the *Employment Contracts Act* was passed in 1991, because expenses for volunteer workers were then legally obliged to be administratively accounted for, with a similar order of administrative costs as if the volunteers were fully employed.

Peer workers could potentially be recruited from clients, if such clients became known, possibly through a drop-in type of programme. However, given the risks of current drug users actually injecting or trading drugs on the premises, many co-ordinators, volunteers and Trustees did not want to run such risks. A 1990 review of the NEP commissioned by the Department of Health noted that one of the peer exchanges promoted a drop-in environment, some tolerated it, and some opposed it (Robinson, 1990). A review commissioned by the Ministry of Health in 1994 paid less

attention to this aspect, but emphasised a series of conflicts between the Trust Boards and their employee managers (Walzl, 1994). This suggests that the risks of drug use on the premises had been successfully managed between volunteers, Trust Boards and employed managers, but that the somewhat related risks of employment by a Trust Board could not so readily be managed.

In the 'shop front' approach, IDU clients brought in and utilised their personal and peer understandings. These aligned with the material and symbolic environment maintained by peers who were also professionalised, and constituted 'meaningful' places and experiences. The peer workers were recognised as being part of the IDU networks, but these networks were treated as less important than the effectiveness and efficiencies offered by the systems of providing educational materials, information, and syringes through the shop-front infrastructure. This co-ordination of specialised systems seems a recognisably bureaucratic approach. As enforced by the District Area Pharmacist, it was also a professional approach. Aspects of registration, such as a standard qualification and limitations on numbers of practitioners, were more important than promoting the individual differences and increasing the numbers of peer volunteers.

A different model might have treated the part-time workers as unique, because each controlled access to a different personal network of IDU. These networks were not static, regular linkages where the even diffusion of neutral information could be relied upon. The IDU networks were constituted from continuing and changing interactions. Such networks produced somewhat durable patterns of interactions. These acted as boundaries and channels, partly due to their material aspects, which took energy and organising to alter, and partly because human expectations and social technologies made some activities easier, at the expense of others that became more difficult. The movement of syringes and information along IDU network connections was more or less difficult, depending on the positioning and changes in meaning associated with the activity of such moving. The public access to the central exchange site partly overcame the particular boundaries that protected any injecting activities that happened in private homes.

In such IDU networks, the information from some people and organisations was more trusted than from others. Even if information passed through or around boundaries, it changed in its meaning, especially that of trustworthiness, depending on its source and route. This was why DIVO, for example, ensured that its IDU personnel were of high standing in local IDU networks. New peer personnel have been required to be approved by DIVO's existing peer-professionals as well as by being selected by the two³⁵⁶ DIVO co-ordinators (Richardson, 2003. pers. com.). This collective logic did not eventuate in CIVDURG, where a managerial logic open to self-interest and narrow

356. DIVO has, after learning about the implicit problems of becoming dependent on a single co-ordinator, insisted that there be two co-ordinators. One specialises in outreach, the other in managerial accounting. This basic safeguard seems to have worked very well for providing continuity of organisational memory and avoiding co-ordinator capture.

perspectives held sway. In making 'safe using' information follow the actual IDU networks, the number of peers would be increased to maximise the coverage of IDU networks. In this model there was still 'carrying' of messages and meanings, yet nothing was carried in quite the same way, because IDU experiences and practices were different. The principle of 'safe using' might have been formulaic and universal, but the mix of peer and professional methods and contexts of drug use were not, since the personal relationships, local cultures, and types of drug using practices were complex, changeable, and dense with desires and fears.

The District Area Pharmacist dealing with CIVDURG had been acting as if a manager in terms of a more bureaucratic model. This might have been appropriate under the IV League proposal for peer outreach workers to be employed within a Department of Health hierarchy. It was not appropriate for the contractual and autonomous peer outreach model that actually eventuated. As this peer model developed, IDU access and coverage increased, yet so also did managerial needs, since individual IDU resisted a one-size-fits all management style. Intriguingly, the District Area Pharmacist treated the CIVDURG co-ordinator as if both were directly accountable to the AIDS TaskForce. Both also ignored the co-ordinator's accountability to the CIVDURG Trust Board as an employee. Robinson (1990: 19-20) also noted such tendencies towards discounting the autonomous authority of the Trust Boards.

The relationships of trust inside CIVDURG were initially strong, despite the later problems. By contrast, the regulatory supervision by the Department officials was initially problematic, despite later ameliorating. The shifts in both sets of parameters of trust occurred in an environment of reduced financial resources, of regulations that prohibited the safer supply of preferred injecting equipment, and of consequent constraints on service coverage. The IDU clients trusted the CIVDURG peer personnel to embody the expertise of current IDU, while also providing types of information and a distance from law enforcement characteristic of the professional health sector, while also being professionally competent in managing the needle exchange infrastructure and premises. Yet the health agencies that funded CIVDURG, and sheltered the IDU clients, trusted that illicit drug use would not occur, either on the premises or within the boundaries of the service provision aspects of the programme.

These developing problems erupted when the District Area Pharmacist informed the AIDS TaskForce that the CIVDURG co-ordinator was not an 'ex-user' as originally claimed, nor was compliant on a maintenance programme, but had been supplementing her medical opiates with street drugs (Lewis, 1989). The District Area Pharmacist hoped: " that the grant of money to CIVDURG in ChCh is not being used to pander to the drug-related needs of the group's staff" (Lewis, 1989: 1).³⁵⁷ The information that he acquired about the CIVDURG staff from the A&D

357. One issue is that most illicit drugs in New Zealand are Government subsidised medicines that become diverted to

sector was expressed in terms of an abuse of trust. However, the treatment clinics did not have exchanges on their premises, in order to avoid compromising their regimes and logics of enforcing abstinence. The surveillance by the District Area Pharmacist and A&D staff illustrated the inherent hybrid ambiguity and conflicts when IDU were also professional colleagues who operated their own health service agency.

The District Area Pharmacist was accountable for promoting the NEP, which had been limited to a pharmacy-based scheme, but had come to include peer perspectives and peer practices.

Nonetheless, he was acting as if the NEP was still a pharmacy-only programme which merely required complying with official regulations under authoritative supervision. It seems likely that no officials had informed him that the autonomous peer groups would be highly responsible for their own management, and far less open to external monitoring than the pharmacy NEP outlets.³⁵⁸ The prospect of further alienating distrustful IDU through surveillance of their medical records would seem to jeopardise the combined peer and professional character developing in the NEP. State agency officials, who needed to be negotiated with over funding and performance contracts, had come to hold information about the non-compliance of peer-professional negotiators with their opiate maintenance regime of treatment. In this incident, peer-professionals gained extra reasons to keep information from treatment specialists and the District Area Pharmacist, yet these needed to be co-operated with to improve the IDU and public health outcomes of the NEP.

It is difficult to see how health sector employees could realistically control 'criminals' who were not dependent on their treatment services.³⁵⁹ Such attempts problematised the preferred collegial practices of the same professionalism that, in theory, legitimised the surveillance of patients. The District Area Pharmacist's complaint seems to have been ignored by the Department's NEP authorities. These Department overseers needed working IDU peer co-ordinators more than they needed critics who could not themselves undertake such work. I find no record of further complaints, despite later problems. This suggests that such surveillance was no longer used so directly. Because the peer group environment involved pervasive entanglements among its peer and professional shaping of crucial permissions and autonomies, 'peer-professional' types of activities

illicit markets and use. Another is that many drugs would be paid for from state supplied incomes. It is not actually a crime in itself to direct state income to illicit ends. A further issue is that illicit drug use requires one to be consistently dishonest when communicating with enforcement authorities.

358. Trustees such as myself considered the accusations to be a private medical issue and a Clinic regulatory issue rather than a needle exchange issue. The peer Trustees could not really believe that members of the public would be so naive as to imagine that peers would not have to be current illicit drug users to maintain peer access. These Trustees were not aware of any need for outreach because they had been recruited to run the exchange and do organisational and survey work. They had absolutely no idea of the history of events that had led to the formation of the NEP and the peer groups. The CIVDURG Trust board was later required by the AIDS TaskForce, in 1990, to formalise its position on drug use by employees. The Board unanimously agreed that, providing drug use did not interfere with work capabilities, off-site employee drug use was a private matter, and none of it's business. Drug use by personnel in general did not seem to affect CIVDURG's capabilities since, being always stigmatised for drug associations in any case, the Trust was not brought into any extra disrepute.

359. It is only the client's dependency on Methadone Programmes that allows the enforcement of 'treatment' regimes.

and perspectives became selected for, not only in the peer groups, but also across the boundary connections into adjoining organisations and occupations.

It can be seen here that the peer-professional logics of such situations stabilised the peer aspect of the NEP and reduced the contagiousness of blood-borne diseases, yet were themselves contagious to a degree. The District Area Pharmacist's position was not workable if it conflicted with the IDU realities that made peer needle exchanges necessary. However, close contact made conflict inevitable because of different operational and cultural expectations. 'Neutral zones' of expectations, such as the NEP peer group policy of 'neither condemning nor condoning illicit drug use', were introduced and maintained in order to facilitate such separation.³⁶⁰ As these logics became apparent, the state health sector largely abandoned attempts at local control in detail. Instead, evaluations based on quarterly reports became formally relied on.

When the peer group co-ordinators wrote the quarterly reports, any problems of structural relations between the Trust Boards and employees remained invisible.³⁶¹ The peer exchanges were left to regulate themselves through attrition, being mentored at times within the local health sectors and by AIDS service organisations, and supported in general by a secure, though minimal, financial foundation of user-pays sales (Kemp, cited by Brunton, 2004 pers. com). The first significant disagreement between CIVDURG's co-ordinator and Trust Board involved responses to a robbery and assault at the premises in April 1991.

Picture 4: Working by myself on an evening shift

(Personal records, 1989-early 1990s)



A volunteer/Trustee working alone at night was assaulted with a broken bottle (part. obs.).³⁶² The

360. Such separation is artificial and misleading, yet, for that very reason is extremely useful and health promoting. It does not even seem unusual in type, only in the intensity of its managed contradiction.

361. Funding agencies had to insist that annual reports from South Island groups must be sighted, authorised by the Boards, and co-signed by Chairs of Boards. The need for such demands indicates how inconvenient some co-ordinators found such scrutiny.

assailant was not a member of any IDU client group.³⁶³ After the assault, issues of worker safety were discussed, leading to disagreements. This was the first time that any tension between Trustee and worker roles seemed both contentious and significant. As workers, peers generally felt they should follow the co-ordinator's directions, and as Trustees, they wanted such co-ordination to be provided. Yet in being Trustees as well as workers, they also wanted to discuss the issue further and see if arrangements for greater safety could be workable and affordable, especially for women alone on the evening shift. There was no security architecture such as grilles and barriers.

The co-ordinator resisted any discussion of extra expenditure, while working herself only during the day with staff at neighbouring shops on hand. Accordingly, some peer Trustees began to lose confidence in the co-ordinator's sensitivity to Trustee and worker perspectives. They began to feel that despite supposedly employing the co-ordinator, contentious decisions were being made not by the Trust Board in the Trust's interests, but by the co-ordinator, somewhat in her own interests. The co-ordinator, in turn, began to lose confidence in the support of the peer Trustees. She began to introduce more loyal personal friends onto the Board, relying on the existing trustees not being prepared, as peers, to challenge the suitability of another IDU without clear cause.

By 1994, Rodger Wright had died, and the internal trust connections of CIVDURG had collapsed, as had external trust connections with local AIDS service organisation branches, and with community health groups. This increasing isolation placed strains on the trust connections with local IDU. In terms of being an IDU resource, and as representing local IDU, trust was diminished, and seemed heading towards dissolution. These increasingly inter-linked problems would have been a traumatic experience that most likely worsened the co-ordinator's "fragile psychological disposition" (Christchurch Press, 1992: 5). These problems also diminished CIVDURG's stability, since the co-ordinator proved impossible to separate from the organisation without legal battles and counterproductive publicity. This structural problem could not be acknowledged outside the organisation without jeopardising the funding.³⁶⁴ Such problems seem an inherent risk when contracted public health agencies are essentially autonomous, while those with inside knowledge have funding incentives to keep silent.

There were public or at least officially recognisable indicators of CIVDURG's problems. In June 1994, at an IDU Group Meeting with the Public Health Commission to discuss forming NENZ (as discussing in following chapters), all delegates except one were co-ordinators or trustees. The

362. See Christchurch Press (1991a: 3, 1991b: 2), Keenan (1991). The worker was dazed but recovered within days. The assailant suffered vascular, tendon, and nerve injuries to the inner wrists from a broken bottle that required prolonged medical treatment. The assailant's recovery was impeded by being repeatedly assaulted in prison by inmates who disapproved of aggravated robberies of needle exchanges.

363. He was a member of a small group of 'homeys' who had threatened several people in the area over the preceding weeks. They had severely injured a Japanese tourist in the preceding week.

364. When DIVO suffered a lesser degree of such problems, the Southern Regional Health Authority reduced its already minimal funding until proof of stable Board functioning was provided. Yet the only proof lay in surviving for a period without complaints, while cutting back services due to the reduced funding.

exception was CIVDURG's combination co-ordinator/trustee (Auerbach, 1994c). By then, being both co-ordinator and trustee was a matter of survival, since there were only two other Trustees recorded in CIVDURG's minutes.³⁶⁵ CIVDURG's Constitution, as amended in 1991, called for a minimum of twelve Board members: "with a balance between IDU members, health care workers, and other interested individuals" (Co-ordinator, 1994).³⁶⁶

In addition, a report on needle exchange issues by Kelly Auerbach (the NEP Co-ordinator employed by the Public Health Commission in 1994), contained lists of the problems experienced by the regional AIDS Service Organisation branches (Auerbach, 1994d). The New Zealand Prostitutes Collective branch in Christchurch reported problems with CIVDURG's lack of confidentiality. The NZAF noted that they never heard anything from CIVDURG. Yet the Southern Regional Health Authority described its relations with CIVDURG as happy and healthy (Auerbach, 1994d).³⁶⁷

By 1994, the contract negotiating agency for CIVDURG had devolved from the Department of Health, through a brief interval with the Public Health Commission, to the Southern Regional Health Authority (SRHA). The SRHA acted on behalf of the Ministry of Health to provide regional health services. It was only after CIVDURG's outputs as provided in the Quarterly Reports started to indicate reducing sales³⁶⁸ that the SRHA later claimed to have become concerned (NECO, 1994c; Nimmo 1994a). Nevertheless, such evaluation by contract outputs seemed somewhat more effective and efficient than surveillance by the regional health officials. Yet such monitoring entailed a delay until IDU responses, as changes in purchasing behaviour of IDU networks, became recorded as sales data.

Falling sales statistics created a problem for the SRHA officials. The Ministry of Health and SRHA staff could not take over the affairs of an independent organisation, especially without themselves having access to the relevant expertise. Yet there were no similar organisations that might be offered a contract. The Ministry of Health had minimised the number of contracted peer groups, and the CIVDURG co-ordinator had not wanted competition. None of the health and social work professions or organisations in Christchurch had attempted to provide alternative peer needle exchange services at a level adequate for the city-wide IDU networks.

365. CIVDURG formally claimed five Trustees including the employee (Auerbach, 1994c, 1994d), but three could not be produced in the flesh at meetings according to minutes of meetings throughout 1994 that could not begin due to lack of a quorum. One was a Samoan elder who told me that she was extremely annoyed at being misrepresented. She had merely attended a meeting in response to a request, and had only agreed to 'consider' becoming a trustee. She had considered otherwise, and had not attended further meetings. However, her name had been placed on official documents as a trustee. Good relations with the Samoan community had been jeopardised in this tactic.

366. This clause had been inserted as a long term safeguard at the instigation of peer-professional Trustees who wanted to counteract the stacking of the Board by the co-ordinator (1994 pers. obs.).

367. The SRHA was later sufficiently concerned that CIVDURG's problems did not become public knowledge that it made its offer of future funding contingent on maintaining secrecy (NECO, 1994d).

368. Sales might be expected to plateau at some stage, but never reduce across a region in a short time. Sales reduction limited to any single outlet implied that clients were preferring to go to alternative outlets.

The two directions and forms of trust that sustained the peer exchanges were no longer aligned. The IDU and AIDS service organisations had ceased to trust the co-ordinator. However, the Ministry of Health and SRHA officials remained trusting, since their information and capabilities had become dependent on the peer-professionals they had contracted. The Ministry connections with CIVDURG were centred on two types of contract. One focused on improving mental health outcomes, for instance through printing several issues of a magazine. The second type of contract aimed at running a shop and maintaining a legal corporate identity, but not of continuing community engagement and outreach. Formal outreach by supervised employees was not funded as a primary goal, even if mentioned as a desirable secondary goal. IDU goals of autonomy and decriminalisation were not funded by the Ministry, although any surveillance information provided by peer-professionals was desired. CIVDURG's collapse seems inevitable due to these misalignments, yet also strangely delayed. The delay was, I think, partly due to the earlier setting aside of the District Area Pharmacist's criticisms of CIVDURG, but mostly due to the SRHA's incapacity for evaluating across the boundaries of its contracts with peer groups. When relevant criticisms were made, officials had to rely on previous records and trust.³⁶⁹ Yet these were inherently private.

The peers involved in NECO, which stepped in between CIVDURG and the DISC Trust management, were unaware of the history and structure of the funding situation. The SRHA's books were not open. An official representative of the SRHA declared that even if the NEP services continued there was no guarantee of continued funding, and that any possibility of funding depended upon there being no publicity about what had occurred (NECO, 1994a, b). This perspective encouraged forming an alliance with the NZAF in order to ensure continuation of services, since the peers in NECO could not access bridging funds.

3 Peer-professional patterns emerge from private problems

This account has emphasised how entrepreneurial founding situations, combined with requirements to maintain a multi-stranded support network, created systemic difficulties. A peer-professional co-ordinator came to distrust the Trust Board which was founded to employ her. This distrust was reciprocated, yet due to the hybrid niche in which the peer groups operated, there was no effective external accountability. The registration process provided a significant governance function by

369. Helen Clark had, as Minister of Health, attempted to enforce a directive that employees could not sit on the Trust Boards of peer needle exchanges. This directive was opposed by the AIDS TaskForce, which wished to preserve the presence of two exchange founders on their respective Boards. It seems unfortunate that Clark was not successful, given later events. However, National won the 1990 elections and the new Minister allowed the directive to lapse. It seems that no official was prepared to enforce it without Ministerial support. A compromise was negotiated whereby employees could sit on Boards but not vote on their own work conditions. This did not prevent employed co-ordinators from influencing the work conditions of peer Trustees.

recording the identities and limiting the numbers of the part-time workers. Such limitations restricted those activities where effectiveness was directly proportional to the numbers of peers. Because this aspect was not formally recognised, the informal outreach provided by the peer-professionals was excluded from formal monitoring procedures, and could not be easily evaluated.

CIVDURG's initial viability depended on receiving the direct and continuous approval of the District Area Pharmacist, and indirectly on the hierarchical Department of Health structure that linked surveillance to funding. The Department of Health funding contract enabled CIVDURG's service to potentially become more specialised by employing people with professional skills. However, the funding also created more dependency on official monitoring and approvals than any unfunded, volunteer-based community groups would normally experience. Nobody in this situation was sure who was accountable to whom, and in what ways. There had been no testing, no persuasion, to define the extent of rules and possible ways around them. This initial pattern continued because the funding contracts did not significantly alter this situation, and the IDU networks were generally unconcerned so long as the syringe supply continued. State agencies and AIDS service organisations could not directly intrude into private peer organisations without adverse consequences. Because the peer groups had been planned to maximise the benefits of local autonomy (Robinson, 1990: 6), specific goals and resources needed to be dedicated to overcoming the vulnerabilities of isolation. However, these conflicted with personal goals of career advancement and protection of privileges, in ways that could not be controlled by a Trust Board that allowed itself to become dependent on a key employee.

CIVDURG helped to normalise the self-injection of illicit drugs and to construct a concept of an 'IDU community'. However, at least three differentiations of this concept immediately appeared. One consisted of IDU who were not linked with needle exchanges. Another consisted of NEP clients, while the third consisted of peers who worked in exchanges, or in other harm reduction sites. Peers were the most visible, publicly useful, and accountable of these three groups. Accordingly, they came to represent the others through the accounts and data they produced, and through their visible compliance with funding contracts and regulations. The peers told a story that was reasonable, with no counter stories.

The peer-professional NEP services in New Zealand continued to operate and gain experience of the new field, with all except CIVDURG increasing in capabilities and resources. They were not absorbed back into the conventional health professions after an experimental initial phase. Two factors have seemed involved. One was the continuation of drug prohibition.³⁷⁰ The other factor lay in how state agencies found it productive and stabilising to contract professional health services to

370. Despite its medicalising having reduced somewhat, as drug taking for recreational reasons became less indicative of a psychological dysfunction.

small, funding-dependent, and legitimacy-seeking groups. Unprofessional activity by these groups could be ignored, because the short-term concerns of all stakeholders to avoid publicity were aligned. Larger health professions, such as pharmacy, had more numerous and wider-ranging strategic options in their conflicts and negotiations with officialdom. The pharmacy members of the NEP were more independent, yet were expected to fix their own internal problems. Mr Pollard's illicit pharmaceutical syringe supply illustrates how such expectations and actualities of autonomy might become aberrant due to urgencies, such as the public fears of HIV/AIDS. Peer-professionalism explains why criminal associates were allowed to begin a second strand of the NEP public health services, despite their activities representing an illegal type of practice and person. Such representation became less acknowledged as a formal goal after the initial two years of the NEP. Yet such representation seems implicit and expectable, since health provision had in general been organised as a high status, legitimised activity.

CIVDURG's development and collapse was partly a matter of a unique place and persons, was partly caused by the national health sector environment, was partly due to the trajectory of an increasingly isolated organisation, yet was also an aspect of the institutional culture of NGO AIDS service organisations. Local organisational problems were pervaded by their peer-professional institutional environment. This environment was initially vertically-oriented due to being positioned within the Department of Health hierarchy, yet was also horizontally-orientated through connections with health treatment organisations and practitioners, while also being pervasively peer-oriented due to IDU being 'everywhere'.³⁷¹ This peer-professional environment characterises the case of CIVDURG. The desire of a peer co-ordinator to access morphine maintenance conflicted with her professional desires to improve her qualifications through an addiction counselling training course. The desire to access morphine maintenance also conflicted with her professional requirement to prevent conflicts of interest with the health professionals on the Trust Board of the peer group. These conflicts, and distrusting, were too intense to be hybridly twisted into productivity.

CIVDURG did exhibit a hybrid type of occupational and organisational interactivity around new boundaries. Even though extremely small and limited in some ways, in other ways it participated in providing national coverage along with somewhat similar peer groups which shared its operating regulations, harm reduction principles, and funding regime. It offered a form of organised collective representation to its IDU clients, while offering peer-professional career aspirations to employees. CIVDURG engaged with regional AIDS service organisation branches and drug treatment agencies. These alliances required differences and conflicts over territories to be negotiated. CIVDURG provided adequate health services for several years while developing a specialised expertise. However, CIVDURG's boundaries shrank. CIVDURG resisted becoming

371. See Fougere (2001) on concepts of heterarchy in New Zealand health sector developments.

intermeshed between the core hybrid activities, an evaluation structure, and a distributed identity that could increase its quality of care. It did not provide a sustainable model of empowerment, was not financially stable, and continually lost its initial structural alliances.

CIVDURG was part of a new type of state agency activity that was simultaneously public and private, lay and professional. In its surveillance activities, and in being itself monitored in part, CIVDURG produced group labels, forms of privileged information, and boundaries that articulated a changing network. This interactivity made it feasible to separate Canterbury IDU networks into somewhat more measurable and controllable groups, such as opiate, ritalin, methadone, and steroid injectors. CIVDURG was acting in part as a state agency in carrying out such surveillance and 'community-boundary-establishing' work. Yet, CIVDURG also carried out work that normalised and even valorised illicit drug users. Such work destabilised the conventional state agency goals of law enforcement, and of maintaining stigma by allowing or causing harm, as in punishment and deterrence or restricting health care to deviant groups.³⁷² CIVDURG's formation and collapse inadvertently contributed to new understandings and connections between IDU and peer-professionals. In the process, the possibilities and expectations experienced by participants 'drove' a reconfiguration of expertise and practices, from Pollard's in 1985, to CIVDURG in 1989, to NECO in 1994, then to the DISC Trust in 1995.

These difficulties resulted in CIVDURG moving from a peer-professional environmental niche, to becoming exposed and vulnerable as 'peer'. As an autonomous organisation dominated by a single employee, the co-ordinators substance problems became the organisation's problems, as both lost their shelter in the professional health sector. CIVDURG became and remained structurally integrated into one personalised whole, due to its Trustees taking an unprofessionally low profile. This environment was initially an experiment, but continued because the alternatives seemed too difficult, and officials were very cautious of a public backlash (Fithian, 2004. pers. com.). In consequence, conflicts between collective IDU practices, professional accountabilities, official codes, market contracts, and community group co-ordination were repressed.

The DISC Trust, which was set up after the collapse of CIVDURG, achieved far greater control of its finances. It re-established mutually beneficial relations with health and AIDS service organisation networks, while keeping any internal problems away from adverse media or community criticism. Peer and professional roles were restructured into a more corporate form of peer-professionalism which involved clearer layers of authority and accountability. A peer-oriented volunteer-worker layer was separated from a professionally oriented governance level of trustees. The separation was maintained through a managerial level consisting of a single employed

372. For instance, IDU were deterred from illicit drug use by the mental health hazards and removal of agency caused by imprisonment. They were also not provided with a comprehensive youth focused harm reduction programme in schools to prevent neophyte injectors from catching HCV.

manager. This structure focused much of the distress and risk and uncertainty inherent in 'peer-professional' working environments through the single link of this manager. Whether more general community empowerment goals have been achieved by selecting managers who are unusual, or trained to handle such stress, seems an illustrative question.

The institutional configuration and wider environmental contours of the NEP has seemed to provide conditions that have encouraged a structural bias against managers being IDU, or being dependent on illicit substances. However, removing a structural bias towards 'co-ordinator capture' by making managers accountable and easily replaced, has increased peer empowerment by minimising the problems of harmful management that in the case of CIVDURG, drove peers away from participating. How organisational goals of convenience and stability interface in peer-professional ways with IDU empowerment seems a crucial issue deserving of further study.

CIVDURG was founded in an entrepreneurial spirit and times, with active mentoring from the NZAF. As with other peer groups, the qualities suited for innovation were not so suited for stable, incremental growth and networking. The DISC governance model has appeared successful, not just due to the counter-example of CIVDURG, but because it has lasted the distance and continued to innovate. CIVDURG need not have collapsed if different people had been Trustees, and if Department staff had acted as public servants rather than contract managers. However, the key point is that the DISC Trust has not needed to rely so heavily on such contingencies.

The DISC Trust managed to attract a number of younger anarchist peers and a qualified journalist, who provided a sequence of editors for the Trust's peer magazine for ten years. If anarchists remain with an organisation, it indicates that its communication and exercise of controls is relatively open and accountable. Nonetheless, it would be unwarranted to assume that structural boundaries fully explain the record of stability of the DISC Trust, or that the lack of organisational structure adequately explains the instability of CIVDURG.

I would suggest that a certain hybrid character has been equally significant. This character has involved the encouragement of professional attitudes, the demonstration of solidly organised innovation, and a collegiate way of organising which has been oriented towards collective mutual interests combined with public accountabilities. The importance of this differentiation is that, although located in organisational activities, the stratified model of DISC Trust peer-professionalism could extend further into institutional arrangements. This appears a not unreasonable prospect, since the DISC Trust has formed several satellite peer groups and given them autonomy once they became established. The extension of this model has not required major policy changes or special exceptions by state agencies.

In this specific, close-range account, peer-professionalism has been presented as a situational type

of hybridity where stigmatised non-professionals took on professional attributes and aspirations. They did this in spaces that had been opened by the withdrawal of professionals from an occupational territory designated by the government. This territory involved inviting IDU participation in a public health programme by providing distrustful IDU with motivation changing services, 'safe using' information, and injecting equipment. In the case of CIVDURG, harm reduction logics provided a link between the criminalised and medicalised aspects of IDU existence. Syringes and information then travelled along this logical link, partly in response to how such activities came to make sense to participants, yet also partly constituting these participants. Accordingly, peer-professional perspectives continue to seem useful in analysing the linked activities of health professionals, hedonistic and marginalised lay networks, illicit markets, and state agency officialdom.

Section 3

Trust, Representation, Regional Infrastructures

Blurring trust boundaries: returned syringes talk about their IDU

Objects of knowledge are material-semiotic generative nodes. Their *boundaries* materialize in social interaction. Boundaries are drawn by mapping practices; “objects” do not preexist as such. Objects are boundary processes. But boundaries shift from within; boundaries are very tricky. What boundaries provisionally contain remains generative, productive of meanings and bodies. Siting (sighting) boundaries is a risky practice.
(Objects As Actors: The Apparatus Of Bodily Production. In *Situated Knowledges*. Donna Haraway, 1999 [1988]: 185)

What factors influenced the returning of used syringes before the NEP was modified by the free one-for-one exchange scheme in 2004? These potentially incriminating syringes have constituted one of the few reported situations where people have offered identifiable samples of personal tissue to agencies of the same government that continued to proclaim its intention to prosecute them. Did the price discount for returns simply remove such considerations, or have additional factors been involved?

In this chapter I will look at how such questions can be approached by searching out the most intense situations of potential trust and distrust to see what actually happened when IDU clients returned used syringes and were monitored at NEP outlets. This analysis continues several themes laid out in previous chapters where I explored how the early development of peer participation was shaped by links of differences and similarities with medical and other health professionals. I will focus on the actualities of information and information-bearing objects that have required or produced trust and distrust. I will describe how small numbers of IDU became 'professionally active' in the gathering of information for epidemiological research as well as for evaluating the NEP.

I begin with names, since the ordering of information involves the ordering of categories in processes of patterning, grouping, and the naming of names. Needle exchanges have appeared strangely and indicatively named. The focus on ‘needles’ seems odd when a hypodermic syringe includes a needle, yet a needle does not include a syringe. However, the term ‘syringe exchange’ is not generally used in New Zealand. People refer to the ‘needle exchange’, which seems more redolent with meaning. The needle is inscribed with meanings that include the syringe more than the meanings of the syringe include the needle. I presume this because it is the needle, not the syringe, that penetrates the skin and simultaneously slips inside the sensibilities shaped into social membranes as moral boundaries (Douglas, 2002: 66, 160-172; Otis, 1999).

Syringes act to locate and feed the hollow needle in measured ways, yet the needle also measures its length inside human bodies, as an invasion to some or as a cyborg celebration of calibration and

precision to others. The precise amount of drug being injected is generally very important to IDU, who balance maximising reward and minimising risk in any instance of injection, yet who also attempt to control the risk or degree of dependency.

In such activity and representations, the movements of objects such as syringes and needles are seen to relate to changes in meanings, as names act as entities in stories which link archival accounts of the NEP to current injecting and administrative practices. Syringes have not only carried and performed symbolic meanings. When used syringes have been returned for exchange, they have carried bits³⁷³ of users' bodies, making the actual 'whole' body of an NEP client accessible to biomedical analysis and trials of ownership. Accordingly, syringes have carried trust and distrust, being simultaneously connected in embodied embeddings, and disconnected as a form of commodity used in a range of exchanges of knowledge.³⁷⁴

The circulation of syringes across market exchanges of property, among differently motivated people, and between the areas and types of mutually exclusive logics of institutions, has involved instances of NEP peers coming to represent IDU, and of IDU coming to represent syringes. These two form of representation have been mutually influencing. They have overlapped to form a zone of activity, where information about other network participants, and about motivation changes by IDU, has contributed to the methods and goals of the NEP.

To provide empirical detail and lay out the linkages of the pragmatic necessities, health goals, and the trust that I argue contribute to the ethos and an ethic of the NEP, I have built up this chapter using three sections. In the first, I account for the foundational contingencies and the continuing environment of decision-making. I do this by showing how returning syringes was needed for the NEP to be acceptable to the public and to health professionals, despite being problematic and costly.

I then outline in the second section how biomedical testing began to 'follow' syringes and IDU in processes of surveillance, producing information and evaluations. I first focus on gay community concerns over threatened biomedical claims to the ownership and redefining of gay collective identity, in this way contextualising and leading to specifically IDU aspects of trust and distrust due to biomedical forms of monitoring of syringes. I then present what was publicly known about the protocols of monitoring returned syringes.

In the third section, I relate particular consequences of these developments to my argument for the general hybridity of the NEP and to its specifically peer-professional aspects. I draw attention to

373. 'Bit' is used here in the sense of a discrete physical object, a partial condition, and an informational object that is the smallest, irreducible reference to a single feature, in this case genetic identity.

374. An informative comparison is to condom use, which has been resisted by some men because semen in the condom has the capability of travelling further afield than desired and becoming accessible to harmful witchcraft. Witchcraft has been understood as strategies for control over uncertain unwelcome events, which might well include having one's DNA recorded in a commercially valuable database of known IDU. See Barnett & Whiteside (2002: 331).

the way the NEP peers and syringes were constituted as representing IDU communities, yet while also modifying IDU life-worlds. In these processes I show how both became institutionalised as worthy of trust, while requiring to be trusted for the NEP to be workable.

1 Making syringe returns count

Although medical professionals in 1987 had demanded that the exchange of syringes be obligatory, in contrast to supply alone; the health officials planning the NEP had introduced a system of standalone supply. This was paid for and therefore largely controlled by IDU clients, with only a discount to encourage exchanges. Obligatory exchange, if frequent, reduced the likelihood that used syringes were available to be reused, which reduced the possibility of sharing. Obligatory exchanges also reduced the likelihood of used syringes being deposited in public places. Obligatory exchange, accordingly, helped to preserve the public and political support for the NEP. However, the incentives for the NEP's providers of syringes to encourage returns were modest, and countered by disincentives.

In May 1988, various health professionals had agreed with the AIDS Advisory Committee that replacing the goal of obligatory exchange with voluntary exchange was unacceptable.³⁷⁵ This demand from a health professional perspective was connected, via the NEP's user-pays commercial environment, to an inbuilt conflict of interests between the price discount on returned syringes and the seller's mark-up on the buying-in costs of every syringe supplied. A director of a methadone service commented: "It would appear that those professionals prepared to do this work are being asked to either subsidise the departments [sic] costs (of providing a financial incentive to IV users to return old syringes), or discourage users from returning needles (and thus get the higher service fee)" (Gray, 1988). If a discount applied, the mark-up reduced, creating a disincentive for sellers to handle returns. Since the extra labour of handling returns did not generate extra payment, profitability per item dropped below that of a non-return transaction.

Since the professional fee components and the returns incentive were of the same order, there was little financial incentive for NEP outlets to encourage returns. Yet police and medical professionals argued vehemently for returns being a foundation of the NEP. This situation added to the need for voluntary peer workers who could implement the policy goals that were directly distrusted by other stakeholders. The low level of financial motivation for pharmacists to encourage the return of syringes could be overcome by trusting in peer workers who, in being trusted by IDU, could motivate IDU to return used syringes without needing to increase the financial incentives to IDU.

The NEP's harm reduction logics involved the increased participation and inclusion of

375. See Gonin & Wilkie (1988), Freebairn (1988).

marginalised groups through proxies, in contrast to directly funding the marginalised groups. It would have been politically very difficult to directly fund criminal drug injectors. Yet such logics nevertheless promoted IDU needs and motivations over those of pharmacists.³⁷⁶ Nonetheless, the NEP depended on retaining the numerical support of pharmacists, while trusting that such pharmacists would be motivated to “do the right thing” (Baker, 2002 pers. com.) for professional reasons, without an external structure of incentives.

The following extract in May from a Wellington newspaper editorial touches on the difficulty of creating trust, and on the significance of the manner in which the returned syringes publicly legitimised the NEP, since: “... the scheme’s success or otherwise now depends on chemists and drug addicts building a sufficient level of trust to reduce the number of dirty needles in circulation, and thus reduce the spread of Aids” (Evening Post, 1988). This mix of regulation and pragmatism was not contractual. It was not based on negotiated conflict. It was based on several types of trust, one of which required all of the participants to stabilise the programme and maintain its sustainability.

The effectiveness and efficiency of supplying sterile syringes was maximised by detailed planning, but the ecological, ‘whole system’ concept of ‘circulation’, where exchanges and returns would ensure that ‘what goes around comes around’, received far less attention. Returned syringes were more ambiguous in their constituents of identity and meaning than sterile syringes. This ambiguity increased due, in part, to the IDU-focused goals of safer syringes within private environments conflicting with the non-IDU goals of safer public environments without used syringes. Guarantees of adequate financial reward and national coverage, in a supposedly user-pays market system, also led to ambiguities and quirky workarounds.

Pharmacists both for and against the NEP were united in refusing to be accountable for the disposal of returns (Department of Health, 1987c), while Department of Health staff were reluctant to risk contagion³⁷⁷ by contact with returned syringes (Hadley, 1987). The NEP infrastructure increasingly utilised market arrangements and constraints. These made up for the deficits, or reduced the financial commitments to the short-term, rather than entering into long-term official or professional arrangements that entailed the acceptance of accountability within a health framework. However, these tactics did not provide a mechanism for seamlessly coupling the costs of disposing of returns to a central, co-ordinated infrastructure, nor to the income-generating area of ‘user-pays’. The

376. The NEP did indeed contain a built-in perverse incentive for service providers to discourage returns, since that meant a larger profit on each sale (Stephenson, 1988). The NEP planners presumably realised that the reliability of returns statistics would be improved, since there was no incentive for pharmacy owners to inflate the return rate. Yet the arrangement created incentives for staff to record a non-return sale as a return sale and pocket the discount. It is hard to know how much this factor has contributed to inaccuracy of records.

377. This anticipated contagion was specifically from HIV, but one seems justified in suspecting that, given the professionally qualified background in medicine of most Department employees at that time, fears of biomedical contagion were actually reinforced by stigma.

disjunctive logic of the NEP's market strategy avoided the political, legal, and cultural difficulties of making commitments to the stigmatised practice of drug injection, yet increased the financial difficulties of co-ordinating the NEP.

Syringes needed to be returned to reinforce the hoped for motivation changes in IDU, and to protect public environments. Yet the costs of counselling IDU and disposing of used syringes were both potentially high. Professional counselling was immediately recognised as entailing major problems of supply and cost, and was accordingly avoided.³⁷⁸ However, the 'non-professional' waste disposal costs were only belatedly recognised, and could not be avoided. In June 1987 the Minister had recognised that the disposal of used syringes was a crucial factor in the feasibility of the NEP (Bassett, 1987d). But after David Caygill replaced Bassett as Minister following the 1987 election, this precautionary realisation seems to have been overcome by a need to push rather than delay the scheme (Caygill, 1987a).

The regional decision-makers within the Departmental hierarchy considered that the projected numbers of returns would be fewer than could justify establishing a standardised recovery and disposal system. One Medical Officer of Health considered that there would be only be a few pharmacists involved, whereas any commercial disposal services would be prohibitively expensive even if throughput was small (MacDonald, 1987). Another considered that only twenty-eight syringes would need to be collected per pharmacy per month (Riggir, 1987). As a result of such localised regional perspectives, along with funding uncertainties, as well as the need to wait before gaining more accurate sales data (Baker, 1987a), a fragmented range of local disposal systems became established in an ad-hoc, bricolage fashion. Their presence, once in place, worked well enough to delay the construction of a national disposal system that could be uniform and integrated with the syringe supply system.³⁷⁹

In 1987, the NEP planners had estimated the buying-in cost of the ten-pack of syringes to be \$2.50, as available at the NEP outlets. Because disposable syringes are cheap, this cost might look high, although it included the costs of producing and importing relatively small numbers of safety containers. These costs presumably included printed material, packaging, and local transport. A further \$2.00 was added to this amount to cover disposal costs (Department of Health, 1987d).

The \$2.00 for disposal costs was an estimate from the feedback from the regional health officials who reported on their local capabilities for handling returned syringes. This disposal cost component was presumably designed for some state agency to collect from the pharmacy outlets,

378. As previously discussed, another reason for this avoidance was a lack of confidence that such counselling would be effective if reliant upon voluntary participation by IDU.

379. See NEP (2000a), NEP (2000b), Walzl (1994: 44), Walker, Brady, & Baker (1994: 2, 31). Later problems of disposing of diabetic syringes could have been avoided if both syringe supply systems had been integrated at this early stage.

or from the syringe importers. The collected funds would then, presumably, be directed to the specific state agency sites where the actual transport and disposal costs of returns were being incurred. However, by February 1988 the budgeted disposal costs had shifted from the health sector to the commercial sector. These costs consequently increased from the estimated \$2.00 within the official health sector to an open market, commercial quote of \$15 per ten-pack container (Health Development Unit Rotorua, 1988).

Initially, the increases in the disposal costs were somehow avoided or absorbed by local units of the Department of Health (Robinson, 1990; Walzl, 1994; Walker, Brady, & Baker, 1994: 2, 31). At some stage, extra funding was presumably made available to compensate these Departmental units.³⁸⁰ Despite the claims of being ‘user-pays’, it is clear that the NEP was centrally funding a significant percentage of the costs of handling the returned syringes. These costs included a component derived from pharmacist’s time, which could not easily be measured, could hardly have been fully compensated, and therefore could be considered voluntary. Only the costs of importing, packaging, and transporting the syringes were met by IDU through user-pays.

In the late-1980s, the neo-liberal changes across the state sector included the introduction of commercial logics and procedures to the internal administration of hospitals (Barnett & Barnett, 2004). The governance of hospital budgets by clinicians was steadily replaced by regulatory regimes and managerial requirements to avoid financial losses. These changes accelerated after National became government in 1990. Along with a new framework for general employment that drastically reduced union rights (Boraman, 2004), the Department of Health was transformed into a governance-only Ministry. The Departmental hierarchy was destructured³⁸¹ into a distributed system of funding agencies and service providing agencies that were rigidly split. The funding agencies received policy goals from the political level and broke these down into various types and packages of services to be purchased, along with agencies that were contracted to provide such services according to specified contractual outputs (Barnett & Barnett, 2004).

The new framework, along with its supportive ideology, created difficulties for any regular use of Department of Health resources for disposing of returned syringes. However, charging the consumers of services then transferring the accountability to NGOs through a contract mechanism was approved in principle since it fitted with the new market model for state activities. This market environment encouraged the addition of service providers for an essential service, yet with no

380. I have found no direct references in Archives. However, such extra funding may have been contentious and made through a single decision of a single agent. Such a decision would be less likely to be recorded.

381. I reject the term restructure and use the term destructure because the overall degree of structure was less in the new system. Whereas a hierarchy depends on structure for its unity of activity (actual or imagined), the new system depended upon contracts that were negotiated between more isolated governance entities. Such contracts were more contestable than the hierarchy of an agency of Parliament. Such negotiations were less predictable. The hierarchy applied all the time, in every decision made by bureaucrats. The contracts were negotiated at most yearly, causing time to be organised, or structured more finely and pervasively in a hierarchy than in a contract cycle.

effective competition, which created incentives for the price of the ten-packs to rise, or for user-pays funding to be supplemented by state agency disbursements. The disposal costs³⁸² could not be avoided, being essential, yet also could not be hidden for long in an ideologically rigid schema of contractual outputs and accrual accounting.

Lorraine Kerse, who was appointed as NEP co-ordinator following Dr. Baker, rapidly realised that the budgeted cost of \$28,000 per year for nation-wide transport and disposal of returns could not be met (Kerse, 1988g). The prior work on budgeting for the NEP's infrastructure would need redoing urgently, or extra funding found to prevent the unravelling of the tentative stability of the NEP enrolment of divergent interests. Apart from the increases in the disposal costs per pack, the indications were increasingly that the NEP would be more utilised than initially assumed, rather than less. This was, in hindsight, to be expected, since Dr. Baker's initial estimate of IDU numbers was based on systemically skewed data. These data were based on inherently inaccurate drug treatment records, and were only later corrected by more useful and valid data from the regular NEP operations and the occasional epidemiological studies.

Uncertainty in the amount of demand for services and syringes did not affect the basic supply operation of a user-pays scheme, provided the users were not deterred by the price of the syringes from participating in sufficient numbers and frequency to prevent HIV transmission. However, uncertainty in demand did affect the syringe disposal costs that the Department of Health was committed to meeting, despite the political pressures to contract out services, to limit the financial risk, and to invite competition (Walzl, 1994: 44). The NEP costs were already high. The delivery, printing, and packaging fees ensured that before the professional fees-for-service and the returns incentives were added, an industry standard price of less than ten cents per syringe had increased to about a dollar. Extracting the waste disposal costs from a user-pays system would have added an extra party to the already somewhat contrived arrangements. Yet, if no further agencies became involved, the Department of Health would have been forced to shift from a purely governance role to becoming a commercial participant and negotiating partner. The degree of safer syringe use needed to lower HIV prevalence and satisfy political goals was unknown at the time. Accordingly, any disincentives to IDU, such as increases in prices, potentially jeopardised the NEP's linked goals of motivation change and safer injecting environments.³⁸³

The return of used syringes was considered essential for the political sustainability of the NEP, as well as to achieve its immediate goals of reducing HIV transmission (Walker, Brady, & Baker,

382. For instance, Christchurch Hospital management had refused permission for their incinerator to be used, because it was already over committed and under-budgeted (Department of Health, 1987e; Thompson, 1987). A Christchurch clinic requested access to the waste disposal facilities of the scheme, despite wanting nothing to do with supplying syringes (Edwards, 1987).

383. It seems likely that user-pays funding made it easier to get the legislation enacted by reducing immediate budgeted costs. User-pays funding reduced the Departmental infrastructure required, reduced public opposition, and accordingly, reduced political opposition. User-pays also followed the pattern set by the illicit pharmacies.

1994: 30-32, 36). However, because medical and other health professionals did not trust IDU, they wanted to make the return of used syringes compulsory. Nonetheless, the health and political officials who planned the NEP trusted IDU sufficiently to offer an option of saving money by deferring the purchase of new syringes. Certainly the NEP's health information directly encouraged IDU to use a new syringe every time. But the NEP's financial logics encouraged IDU to clean their syringes with bleach several times before returning them. After all, exchange was not obligatory and syringes were not free, even when discounted.

IDU payments did not meet all of the NEP costs, since the essential syringe disposal costs were met through state funding. Because the syringe disposal system had become state-subsidised to a degree, IDU who chose to clean and reuse syringes were reducing the overall costs of the NEP. This compromise between pragmatic and precautionary arrangements ensured that a workable goal of reducing the circulation of used syringes among IDU was achieved in flexible ways. IDU were encouraged to participate at their own chosen level, rather than be forced into compliance. IDU had less reason to resist the monitoring arrangements, for instance by one person buying in bulk and reselling outside of the regulated system. Because IDU were not discouraged from using the pharmacy exchanges, and were actively encouraged to use the peer exchanges, they provided an accessible, large enough group for sentinel surveillance.

2 Sentinel surveillance of people, returned syringes, and trust

In 1985, biomedical testing issues provided a focus for turf wars between medical experts and gay HIV/AIDS community organisers over the composition of the expert committees that advised the Minister of Health. One such conflict centred on the control and infrastructure of testing for HIV, both as personal diagnosis and sentinel surveillance. The conflicts over who would take on which roles, using what forms of expertise, translated into a trial of strength over the sites and infrastructure for accessing members of a marginalised community and manipulating the interactions of people, expertise, and information.

Given that the testing techniques were at least partly medical, the conflicting parties agreed that clinics of some sort would be needed. Nonetheless, given that the community expertise was also committed to precautionary approaches and trust relationships, the model of the clinic and its linkages to other community and health sector infrastructures were highly contentious. The concerns about testing community members had focused on guaranteeing personal anonymity. However, such guarantees entailed collective control of the quality of clinical information by communities which were collectively affected by the use and public representation of that information. The control of the location and personnel involved in testing had been made a

community-defining issue. By 1987, gay-focused community groups, such as the NZAF, had ensured that biomedical testing was not restricted to the STD clinics associated with the clinical speciality of venereology, nor restricted to the Communicable Diseases Bureau of the Department of Health. In a variety of complex ways, the inspection and empowerment of marginalised communities became overtly linked in new organisations, as discussed in Chapter 4 and 5.

Similar logics involving the increased hazards of HIV transmission being caused or magnified by stigma were found in both gay and IDU social networks. These logics created a receptive policy environment for IDU to also become conceptually framed as a community. The *Ottawa Charter* (1986) did not distinguish between homosexual and injecting practices, treating both as marginalised, whether associated with individuals, groups, or communities.³⁸⁴ However, the bureaucratic logics of state agencies required an organisation of some sort to represent and provide health services to marginalised communities. Public officials were uneasy when working with private individuals and groups (Baker, 2002. pers. com.) who, unlike officials, did not work within a structure of overt accountabilities. Public funding could be more readily justified when given to a registered corporate body, as in the initial funding packages that kick-started the NZAF and Needle Exchange New Zealand (NENZ).³⁸⁵ In corporate bodies, accountabilities were specified to particular officeholders and constitutional codes. Such accountabilities were specified and legitimised by annual meetings where a membership might alter such arrangements or indicate approval. If unfortunate events occurred, officials dealing with such bodies were unlikely to themselves be held accountable.

Competent, professional IDU did not self-organise in public, because any potential goals of decriminalisation which might justify the difficulties and dangers were clearly unachievable in the short term due to the range and fundamentalist fervour³⁸⁶ of opposition. Public exposure increased the hazards that included arrest, ineligibility for health insurance, barriers to entering other countries, loss of professional reputation, and reduced employment opportunities. IDU faced greater legal hazards than gays, which gave IDU greater cause to protect their privacy. No public IDU groups were known in New Zealand until the IV League was encouraged to form by Department of Health officials.³⁸⁷ However, the IV League was not encouraged to expand beyond a small number of IDU. IDU representatives were not initially considered as independent service providers, unlike gay community representatives. Although New Zealand IDU were known to

384. I consider communities to be groups that define themselves as self-perpetuating through an infrastructure of care.

385. See Chapter 4 for the NZAF founding, and Chapter 9 for the NENZ founding.

386. By this I mean that opponents of decriminalising drug use of various sorts did not generally appeal to rational arguments, but to a dogmatic code that defined drug use as 'evil' and more specifically defined the altering of mood and consciousness as 'evil'. I do not mean that such attitudes were actually written down in a seminal religious text. The closest to an actual text would be Leviticus, but only in the sense developed by Mary Douglas (2002: 51-71) in her analysis of the abominations described in Leviticus where in-between, liminal, 'impure' states were presented as 'evil' and socially dangerous.

387. See Baker (2002) pers. com, Kemp (1996), Robinson (1990).

effectively communicate through market and social networks, such as “the drug grapevine” (Seddon, 1988), IDU were considered, and considered themselves, to be incapable of self-organisation in any conventional political or commercial senses (Wright, 1987).³⁸⁸ Nonetheless, the logics of motivation change required officials to encourage IDU to participate through incentives and by lowering barriers to employment. Both expressed a mutual interest in minimising public exposure.

For instance, by March 1987, the Department of Health officials planning the NEP considered it necessary to categorically reject any attempt to record NEP clients in a register. The officials certainly wanted to record more accurate and relevant statistics for evaluation purposes, as well as developing epidemiological models, but: “this requirement could act as a barrier to people utilising the exchange scheme, preferring to continue to share needles rather than risk their anonymity by having to register into the scheme” (Department of Health, 1987b).

The absence of registration of NEP clients is significant because precise evaluation models, based on correlating client motivations, behaviour, and syringe movements, required the clients to be individually identified. Without identification, procedures of marking individual syringes and measuring their movements were pointless, as well as counter-productive and costly. This is because they would create a separate data-set, leading merely to speculation over the relationship between the syringe movement data and IDU data. An effective procedure needed to obtain data that tied together the key components of the mechanism involved, namely drugs, money, IDU, social networks, NEP outlets, and syringes. Without the general registration of NEP clients, any studies necessarily relied on obtaining individual consents in a process that, in being an exception to normal procedures,³⁸⁹ risked introducing forms of experimental and observer bias.

One reason for IDU to distrust being identified was specified in the Department of Health policy advice warning that: “chemists may wish to use the scheme as a method of catching drug addicts by reporting needle purchasers to the Police” (Department of Health, 1987c). Yet the Minister of Health was urged to put NEP clients onto a register “otherwise you won’t be able to catch up with them” (Williamson 1987: 1). Notwithstanding, the Prime Minister wrote to a disgruntled opponent of drug use, that “we must work closely with, rather than against, those groups that are at greater risk of acquiring and passing on AIDS” (Lange, 1987). Members of the Labour Government Caucus recognised that the NEP was a target for public distrust which had to be assuaged or distracted for the NEP to be effective, and for political risks from the health sector to be justified to

388. See Blewett (1997), Hulse (1997), Price (1992) for Australian and North American discussions of IDU self-organisation. IDU participation might have been expected to emerge by itself in secret market networks, multiplicities, or even pluralities of organisations, but the private nature of such organising, even if small in numbers, would have problematised negotiations.

389. In one case, I have heard of IDU clients exchanging their identity numbers, which effectively destroyed the validity of the methodology of the study (Nimmo, 2004. pers. com.)

Cabinet colleagues (Bassett, 2002. pers. com.). In August, 1987, a senior Department official emphasised that: “it was important to evaluate the needle exchange scheme in view of the controversy” (Stephenson, 1987a).

Shortly after Bruce Burnett’s statements of opposition to compulsory HIV testing (AIDS TaskForce, 1984), the existing anonymity protocols and other protocols applying to voluntary testing situations were being rejected by the AIDS Support Network. The AIDS Support Network instead began publicly offering precautionary medical advice on prevention and palliative care, within a theoretical framework of HIV/AIDS focused psychosocial counselling that insisted that the: “sociological and political aspects of the AIDS epidemic must be included within the medical response” (AIDS TaskForce, 1985b). The service delivery and information gathering aspects became woven together into a new form of expertise outside of the existing professional and official health arrangements.³⁹⁰

Only those IDU who had consented, or had been forced by Court orders into treatment, were in contact with health authorities. This ‘captured’ group seems to have been presented at times as representing all IDU. A representative from an Auckland Drug Dependency Clinic considered that IDU, presumably those in treatment, but presented as IDU in general, would have no objection to being screened, along with prison inmates (McDonald, 1985). Nonetheless, at least one medical opinion from the UK expressed a more cautionary and realistic stance, acknowledging the: “widespread fears about confidentiality ... [but] most drug users will co-operate with voluntary testing if they are sure it is confidential” (BMJ, 1987: 389-390). It seems unlikely that undisclosed IDU would willingly participate in any programme of any sort if their identity thereby became known to enforcement or treatment authorities.

In September 1987 the proposed evaluation procedures for the NEP included monitoring the pattern of syringe sales and returns, as well as the seropositive rates of IDU, although the methodology had not been finalised with the National Health Institute (Johnston & Patel, 1987). Two weeks later an article in the *Medical Journal of Australia* promoted syringe exchange, rather than supply only, specifically to enable unlinked sentinel surveillance. The procedure envisaged entailed the collective monitoring of returned syringes with no link being attempted to any particular individual clients (Wodak, Dolan, & Imrie et al., 1987). The monitoring of returned syringes in New Zealand was first reported in the *NEP Management Plan* (Baker, 1987a). The Management Plan scheduled three monthly seroprevalence testing of all returned syringes, over a

390. This was similar in some ways to post-1960s strategies by many women to resist or side-step a male-dominated jurisdiction by medical professionals over the bodies and information taken from patients. Women activists worked in unifying strategies, through the development of feminist theoretical frameworks; and by diversifying the range of health care practices accessible to women. In consequence, many women increased their awareness of their bodies as consumers of existing male dominated medical commodification services. Some women professionalised, becoming providers of models of care that resisted biomedical methodologies. Such models included nursing, midwifery, woman run health clinics, and alternative healing practices.

one week period, and also suggested testing returned syringes for individual blood types to see if a mix of types could provide a measure of the trail of any sharing of any individual syringe.

The Management Plan also outlined methods of encouraging motivation changes in IDU. These included a counselling component involving IDU peers, along with clinic-based counselling. Peer experience became a crucial feature of the peer group services because it encouraged IDU to identify with and support the goals of the NEP. One goal of the December draft of the Management Plan was to: “provide ongoing surveillance information on HIV seroprevalence amongst IVDU’s, most of whom would not normally present for testing” (Baker, 1987a). The returns testing goal and method emerged before IDU peers were considered as not just involved in the same programme, but actually running exchanges and offering access to normally non-compliant IDU in an alternative site to a pharmacy or drug treatment clinic.³⁹¹

The Management Plan outlined the initial stage of conceiving of the NEP as enabling information-gathering, by means of the recognising and enhancing of IDU peer expertise, as part of an integrated mechanism. A second level of hybridity developed, building on and overlaying the initial level where small numbers of pharmacists acted illicitly to address the immediate problem of preventing HIV transmission. This intensified, second-level hybridity consisted of the NEP’s own integrated sentinel surveillance and self-monitoring capability becoming joined to the peer and professional practices, mutually antagonistic, that had previously made such measurements too difficult. IDU did not particularly want to be monitored, professional biomedical and drug treatment specialists did not particularly want to obtain information through such methods as the NEP, particularly information that indicated the poverty of conventional research methodology in this area. IDU peers later found they did not want to be positioned in the middle of such antagonisms. Yet the pragmatic productivity of the hybrid logics involved could not be withstood.

Apart from the IDU peers, the NEP’s stake-holders were professional health workers or those employed by state agencies, who normally would work against rather than with IDU. Such stake-holders were forced to rapidly change their stance, and could not act authoritatively in their new stance, because IDU participation was voluntary rather than enforced, and formed a crucial indicator for evaluating the workability of the NEP. Attempts to enforce compliance would not only have risked IDU participation, but would also have compromised any methodology of measuring effectiveness and efficiency. For this reason, the surveillance of syringe movements and HIV prevalence in peer-run needle exchanges became coupled with the calculation of IDU

391. In May 1987, the Minister had reassured Dr Meech that: “counselling agencies be established in all health districts and area health boards and that the medical officer of health of each be given the role of co-ordinating them. I imagine that these counselling centres will be willingly established by appropriate organisations or interested groups” (Bassett, 1987c). Peers might have been considered at this stage, but no other evidence has suggested that IDU groups, rather than conventional medical professionals and treatment agencies, were being considered as counselling providers. The statement could be construed as a challenge to medical professionals and treatment agencies to create new centres from their existing resources, or risk official direction of their industry.

populations and the evaluating of the overall NEP in official-run policy centres. There were then no other indicators that could be relied on to evaluate the NEP, as shown by the cost overruns caused by the inaccurate data generated by treatment practitioners.

The long-term evaluation of the NEP required an immediate survey of HIV prevalence among IDU to establish a baseline for later tests to be compared against and transmission rates calculated.³⁹²

The earliest survey used blood samples and interviews, after informed consent had been given, from IDU at a Wellington treatment clinic. However, this survey had been restricted to low numbers, at a site that was too localised to provide information for reliable national planning (Robinson et al., 1987). For such purposes, to reduce selection bias, evaluation based on sampling methods needed a high compliance rate, and a more representative sample than a treatment clinic could provide. Since IDU attitudes to giving samples for testing were unknown outside of such treatment clinic situations, neither the validity nor the cost effectiveness of such tests could be easily defended in advance. Nevertheless, returns testing seems to have become tacitly approved, since no objections or advice is found in the recorded responses to the Management Plan, despite the Plan offering no protocols for NEP clients to be informed and to offer or deny consent.

In terms of the ethics of partnership with affected communities, asking IDU to give their informed consent was similar to asking gays and MSM. If the request was genuine, it might be refused. However, asking for consent from IDU would not only introduce delays, but would reintroduce a degree of volunteer bias if IDU objectors refused to return syringes over the sampling period. In 1989, Dr. Baker, by then positioned as a researcher attempting to develop a returns testing procedure in a pilot study, contacted one peer group to specify the issues, suggesting that:

If we are to justify providing increased resources for preventive education work then it would be useful to be able to target these more precisely. ... It is hard to see any ethical objections to this method of testing as it is totally anonymous, there is no possible way of linking a sero-positive syringe to any individual ... I believe that it is important that the community of interest are consulted regarding all research of this type and I would be grateful if you could discuss this proposal with the members of your organisation. Please let me know as soon as possible if your organisation is broadly in favour of this proposal going ahead or if you have objections.

(Baker, 1989: 1)

Information about the testing might, or might not, leave the exchange, depending on how its membership and controls over information were construed. Nonetheless, the movements of the returned syringes and the access to information by clients would initially be controlled by the peer personnel. Peers were represented in Dr. Baker's letter as experts in the likely consequences of such movements of information and syringes. This letter positions the peer personnel as capable of giving consent on behalf of the IDU clients, as well as being the controllers of infrastructure and knowledge, while positioning the illicit IDU as a valid 'community of interest'.

392. A diagnosis of AIDS could be so long after infection with HIV that little information of immediate use in managing a community programme could be expected.

Dr. Baker was direct in his approach. He left the difficult, discretionary issues to those whose communities were involved, who were more experienced, and who had most to risk. Dr. Baker had, in May 1988, offered an effective 'model contract' of peer outreach. He proposed that IDU peers would promote IDU participation in epidemiological surveys in return for health benefits (Read, 1988). The mechanism of this 'exchange model', as directly discussed by these individuals in their active networks, involved specific circulations of information, intertwining with shifts in motivation by all participants, along with movements of objects and the alterations of meanings of objects, words, and agency.

There was a chance that these peers would not agree, from either IDU or professional perspectives, to accept accountability for representing IDU. No-one knows whether the research could have taken place without consents. However, in 1992 unlinked HIV seroprevalence testing of attendees occurred without consent at STD clinics in Auckland and Christchurch. The Auckland and Canterbury Area Health Boards' Ethics Committees approved those studies without directly informing, or imposing a condition of informing, either the public or those being sampled, or informing the groups that represented those having tissue taken for such surreptitious analysis.³⁹³ The New Zealand Prostitutes Collective (NZPC) had, in good faith, encouraged sex-workers to attend these clinics. When the NZPC discovered their inadvertent role in contributing to such testing without consent, they withdrew their good-will and co-operation.³⁹⁴ Their stance was supported by other AIDS Service Organisations, such as the NZAF and the NEP peer groups (CASONZ, 1991b).

If any commercial agencies had forced or tricked their customers into such biomedical testing, without informed consent, the research would probably have been unacceptable to IDU, to the AIDS Service Organisations, and to academic communities. By contrast, this episode of testing was accepted by medical experts when it was carried out by their colleagues in an official programme, despite or because of an expectation of resistance and distrust by the marginalised community involved, and their representatives. If state agencies had utilised research based on the

393. See Dickson, Paul et al. (1993), Paterson (1996: 40-41). Paterson minimises the problems associated with studies lacking informed consent. He was later appointed the Consumer Health Advocate. He has been strongly criticised by a womens' health consumer group for promoting policies that have further reduced consumer protections for control over their bodies and personal information (Auckland Women's Health Council, 2004). These policies were promoted by Paterson who was acting, in part, as a representative of communities, but not consulting with community groups.

394. "NZPC have been told by Sexual Health Services to use only their services in diagnosing and treating resistant gonorhea [sic], and so sex workers were encouraged by NZPC to go to the Sexual Health Service. NZPC were not aware that data was going to be collected for CDC. A letter needs to be written to the CDC Journal saying that the research is not acceptable social science ... A letter has been written to HRC re Sentinel Testing Surveillance for HIV at STD clinics, and the HRC has responded to the letter and passed on the concerns to the Epidemiology Group. The letters received seem to gloss over these concerns. STD clinics need to be approached and their unlinking procedures inspected. ... The question of who is monitoring the research was raised" (CASONZ, 1992: 4-5). The NZPC was not satisfied with the safeguards and accountability procedures, and would not act as a 'collection agency' for social science research when participants were not offered informed consent (Healey, 2004. pers. com.). Further criticism of the human tissue surveillance being carried out without fully informed consent was made by womens' health groups, for instance Coney (1988).

deception of IDU or peer-professionals, the network of trust connecting IDU to such state agencies would have been jeopardised. Peers would have experienced greater difficulties in encouraging IDU to bring in returns. For instance, one peer-professional noted that: “Most clients report that their reason for not returning syringes is their fear of being prosecuted for that equipment, or that the police will send the equipment to ESR for analysis to support a more serious charge” (Blacklock, 1998). As Kemp pointed out in relation to IDU fears of being identified: “if the Health Department, why not the Police?” (1990: 7). Urging IDU to keep used syringes for later exchange would seem to invite unnecessary risk of arrest unless fears of prosecution were reduced to an equivalent degree, yet the prosecution rates did not reduce (Blacklock, 1998).

According to Dr. Baker, ESR Health ‘routinely’ tested returned syringes to determine the geographic distribution of HIV infection among users of the NEP (Baker, 1994: 1). Baker again described an arrangement as being a form of exchange in a semiformal relationship. He gave ‘ownership’ and credit to the outreach groups for choosing to participate, stating that: “The achievements of DIVA and other outreach groups in New Zealand are to be commended. ESR wish to acknowledge their support and assistance, for without their help the above studies could not have been completed” (Baker, 1994: 1). DIVO minutes record that Dr. Baker supplied such references in support of grant applications, further supporting the concept of a mutual benefit contract (DIVO, 1994c). Official recognition was also received from Healthcare Otago's Health Protection Unit & Communicable Disease Centre, which willingly acknowledged that:

the statistical information on trends of certain communicable diseases provided by your organisation is extremely invaluable for epidemiological purposes. Our organisation looks forward to an enhanced working relationship with DIVO in the most important field of communicable disease control and surveillance. We can only hope and encourage that funding of your organisation is kept at a sustainable level ... (Gradwell, 1994: 1)

These arrangements, together with the way they were reported, could be interpreted as contractual, but given the lack of specified time periods, outputs and date of agreement, seem more collegial or a cross-speciality collaboration.

In Christchurch, CIVDURG's co-ordinator supported the proposal to test returned syringes, yet worker-Trustees, such as myself, were urged by the co-ordinator to not mention the testing procedure to clients.³⁹⁵ In Dunedin, the DIVO co-ordinator responded to Dr Baker's letter by recording concerns, before consenting, stating that: “working trustees are agreeable with this, but we do not feel ~~safe~~ in a position³⁹⁶ to tell our clients that your study on returned syringes for HIV antibodies is being carried out” (Lee, 1989: 1). The phrase ‘feel safe’ indicates that the testing of returned syringes was considered at least potentially harmful if it became known in IDU networks,

395. No reasons were given, apart from 'upsetting people'. A clause in the CIVDURG guidelines instructed workers not to talk outside CIVDURG about any internal matters that would bring the Trust into disrepute. However, this rationale was never specifically invoked to my knowledge while I was a Trustee.

396. In the original text the term ‘safe’ was crossed out and replaced with the phrase ‘in a position’ as I have represented.

even to those who stood to benefit in some ways from the outcomes. For instance, Kemp commented that the: “NHI [National Health Institute] claim that their methodology will allow the pin-pointing of positive equipment to individual pharmacies. However, this would most likely be counterproductive ... it would raise fears amongst consumers of being identified” (Kemp 1990: 7). No records of any attempt to directly inform clients have been found in the archives of CIVDURG or DIVO. Nonetheless, if the peer personnel had passed on the information about the testing, it would have circulated without leaving a record.

These aspects of following syringes and putting them on trial show how the movements of information and equipment were joined in processes of monitoring and evaluation. IDU were not just subjects in the sense of being objectified. Instead, due to the syringes and their peers on the NEP their already existing but conventionally discounted network agency became intensified by means of the network aspects of a more intense surveillance. The surveillance required participation.

Any analysis and understanding of these developments, as well as the more delicate aspects of network agency, would seem to benefit from a Foucauldian perspective on ‘productive power’ and self-surveillance, found for instance in academic literature on governmentality.³⁹⁷ Yet this detailed case example of the NEP shows how the details could not readily be followed and foregrounded from their inconspicuous background using a Foucauldian approach, which tends to use historical cases illustratively rather than groundedly. Instead, we see that anthropological, actor-network methods are more crucial for more closely following and more readily finding these sorts of relationships in the everyday life of people, objects, language, and institutions. And indeed, in the sub-discipline of governmentality, where crime and health intersections are also studied, the more useful work solidifies its theorising in grounded, case study approaches.

The NEP’s peer organisations, being positioned in the middle of opportunities and boundary lines amongst institutional topologies, might have been expected to develop an expertise in surveillance on behalf of the agencies they represented. However, peer needle exchanges were also developing distinct organisational identities, while increasing their peer-to-peer networking in infrastructural and commercial ways. This ‘self-centredness’, in contrast to acting as the agents for others, encouraged the development of capabilities that were organised around their peer activities in a newly meaningful occupational centre, rather than around IDU ‘grapevines’ or webs of state agency officialdom.

The meaning of the activity was not irrational, nor deviant, nor escapist, as drug activities were often labelled, nor an unquestioning obeying of orders. Instead, the meaning was constituted and expressed as ‘work’, with its corollary strands of meaning that linked to values of dignity,

397. For governmentality analyses in this area see Rose & Novas (2003), Rose (2001), Rose & Miller (1992).

legitimacy, and reward. Nonetheless, these peers represented IDU and syringes against the professional medicalising claims to rightfully and legally control IDU, drugs, and syringes. Yet in accomplishing this representation, the peers increased their professionalism. This process required increasing self-evaluation, and a more discretionary control of objects and information, beyond any immediate accountability to IDU or state funding agencies. These professional goals emerged from a collective network need to represent and care for IDU, yet these professional activities destabilised and altered a founding IDU community ethos of secrecy. These paradoxes, which may be less uncommon if looked for elsewhere, seem usefully conceptualised as hybridity, particularly of a peer-professional kind.

The peer groups accepted a position of representing IDU, rather than attempting to transfer such authority and accountability to local IDU networks and individuals. When IDU visited a local exchange, they might be interacted with in terms of a range of individual connections, different drugs, and shifting market aspects. Yet in a different context they might be grouped and referred to as ‘the consumers’ of a health service. In this particular instance of testing returned syringes, a concept of a single IDU ‘community of interest’ was promoted by the gathering and centralising of two forms of representation. First, the single occupational type of peer representative was asked for approval. This was also a tacit request for permission to proceed, since the peer groups might have chosen to not send their collected returns for testing. Second, a single site of evaluation was arranged for the syringes to be gathered, and where all the information from the material syringes, and also from the compliance of the peer groups and pharmacists, could be collected in a single type of place.

The IDU ‘community’ was enrolled in a project of producing epidemiological knowledge, yet also in producing further funding, providing support for policies on NEP developments, and constructing ‘layers of value’, as if wrapping new layers of meanings around IDU, peers, and syringes, while tying these configurations into a package folded from the articulated necessities of peer-professionalism. Certainly there are other processes in which IDU have been presented as a singular group. Drugs and syringes are often represented in media as a singular phenomenon. However, peer groups and peer-professions seem particularly significant because in New Zealand there were no other licit sites where IDU were represented and could be directly negotiated with through a simple, single letter.

The 1987 Management Plan had scheduled three-monthly testing intervals, while Kemp had advocated for ‘frequent’ sampling of returned syringes by the Area Health Boards (Kemp, 1990: 6-8). However, apart from a reference to a prior pilot study in Wellington, Baker et al. (1992) seems the only published and accessible report of returns testing in New Zealand.

Dr. Baker's research results supported the efficacy of the NEP, as well as a need for greater outreach, along with wider and longer duration access to methadone programmes. This New Zealand research was combined with similar North American and Australian research to argue for:

greater collaboration with members of the local drug-using subculture in conducting surveillance and prevention activities ... exchange venues should continue to be used as a venue for [syringe] testing, perhaps using more direct techniques to measure seroprevalence, such as saliva testing which appears to be more reliable and may be more acceptable to IDUs. More specifically, we suggest that this baseline survey should be periodically repeated to provide information on HIV infection trends perhaps with some modifications. For example, although the method used in this survey (i.e. unlinked testing) proved to be very effective in maintaining the anonymity of participants, it would be valuable to collect demographic and behavioural information to assist in targeting prevention efforts.

(Baker, Brady, & Tobias, 1992: 15)

No further reference to syringe surveillance has been found until 1994, when the DIVO minutes (1994c) casually mention that returns were being collected for testing. It was difficult to trace this reference further. Nonetheless, a syringe return testing study was undertaken in 1994.³⁹⁸

Similar testing of returned syringes occurred in the United States. A study based in Connecticut,³⁹⁹ attempted to use such syringes to compensate for the perceived drawbacks of the self-reporting bias of a volunteer study. The study design used a tightly controlled monitoring system that followed the movements of individual IDU and individual syringes through the exchange process. This procedure was coupled with a mathematical model that described IDU and syringe movements within a network configuration. This model estimated the circulation activity of IDU and syringes by measuring the return rates. The modelled calculations were used to evaluate the effectiveness of the syringe exchange. The description of this process is consistent with actor network language in its positioning of needles as actants, for instance in the: "behavior of needles ...[in] a data collection system for 'interviewing the needles'" (Kaplan & Heimer, 1994a: 567-8).⁴⁰⁰

According to this study, information about the reduction in needle circulation times and participant motivation was 'encoded' in the ratio of distributed needles being returned. The return ratio described the relative reduction in circulation times and the penetration of new syringes into the population, since: "In a needle-exchange program, the rate at which needles are exchanged is a

398. A report entitled '*Analysis of Returned Syringes to Map the Regional Distribution of HIV Markers in New Zealand Injecting Drug User Populations*', by Walker, N., Brady, H., & Baker, M. in 1994, is referred to in '*Progress on Health Outcome Targets*' Public Health Commission (1995: 121-122, 149). However, the report by Walker et al. (1994) was not in the public domain. I eventually unearthed this report, which had been held by the Ministry of Health, but had not been released to me as part of the 'complete file' on the NEP. Because it had been privately commissioned to the ESR it was being treated as private rather than public information, despite being commissioned by the Ministry of Health.

399. See Kaplan & Heimer (1994a, 1994b). See also Kaplan (1994), Myers, Heimer, Liu, & Henrard (1993), Heimer, Kaplan, Khoshnood et al. (1993), Kaplan & Heimer (1992a, 1992b), Kaplan (1991), Kaplan & O'Keefe (1993), Kaplan & Soloshatz (1993), Heimer (1995), Heimer, Kaplan, & Cadman (1992), Heimer, Myers et al. (1992). This study was preceded by a more conventional study in Florida (Chitwood et al. 1990).

400. See discussion of actor-network methods in Chapter 2. The U.S. study differed from actor-network approaches in its positivist emphasis on measurements of actual entities being obtained through a rigid research instrument. It did not explore how the research instrument being relied on was an effect produced by network interactions that were even more precise and significant in understanding researchers and those researched as the same 'case'.

function of client participation in the program” (Kaplan & Heimer, 1994a: 570). I agree that this ratio can be used to evaluate such programmes from the outside, but the ‘accuracy’ or better, the ‘relevance’ is less certain than might seem, since it depends on the degree to which the functioning of the IDU network does not change after being calibrated through baseline studies.

By contrast, the history of the NEP has featured significant and continuing change, though more at some times than others. It seems clear that the syringe measuring technique would become inaccurate if changes in IDU motivation led to changes in behaviour, yet these specific changes were a primary founding goal of the NEP in New Zealand. Nor does this U.S work make any reference to obtaining the informed consents of those being measured.⁴⁰¹ Yet any increases in distrust by IDU for this syringe exchange programme due to surreptitious testing would seem to alter the precision of the model, and perhaps even the logic and practices of the mechanism involved.

NEP syringes began to be labelled by the importer in the early 1990s, to identify them for legal purposes, but each individual syringe was not uniquely marked. The labelling practice ceased because the costs were unsubsidised, which increased the price of syringes and heightened the access barrier for clients. The practice also undercut the promotion of a partnership concept by reducing funds that might have become redeployed into health promotion activities. No published New Zealand study has reported using individually marked syringes. This is significant because unique identifiers on syringes would be needed to calibrate Kaplan & Heimer’s mathematical model for precise evaluations of syringe exchanges and associated rates of injecting drugs in specific local environments.⁴⁰²

The Management Plan described a procedure that searched for multiple blood-types, to identify shared syringes (Baker, 1987a, 1987b, 1987c). In mid-1988 such a procedure was specifically proposed (Baker, 1988c), but no actual instances of trying to identify particular individuals, even if anonymous, have been recorded. Nor have I found any proposals for analysing the DNA in blood remnants from NEP syringes. However, in 1998 it was experimentally demonstrated to be technically feasible to analyse any human and viral DNA in used syringes through PCR amplification techniques (Rich et al., 1998). The research that established this technical capability seems unlikely to have been purely disinterested. For example, the isolation of human DNA from household dust was only investigated in 2008 (Toothman et al., 2008). Such NEP capability and forensic interest in DNA in syringes seems well-matched, and feasible to put into practice. Police

401. The 1993 report on this needle circulation theory was criticised by several UK researchers (Green, et al., 1995), who briefly mentioned consent issues among other methodological problems of indirect testing. Heimer responded that he was not permitted by the study sponsor to use more valid, direct methods, and that a mathematical instrument effectively magnified the reduced power of indirect testing (Heimer, 1995: 597).

402. Although a rigorous study of this sort would be needed to calibrate the algorithm, provided situations then did not change, such an equation could continue to be applied to seemingly non-intrusive sales and return data.

could seize syringes for testing in searches of people and houses. The police could presumably also legally intercept syringes between exchanges and sites of professional destruction, since any returned syringe represented a clear reason to believe a crime had been committed.⁴⁰³

Anonymity was easy to build, as a protocol, into the early stages of the New Zealand syringe testing procedures. It would have taken a special effort to record fingerprints from the syringe bodies or to analyse identifying biochemical data from the blood traces. The test protocol called for batching the washings from a number of syringes, which would remove any specific correspondence with any individual injector. In a system that complied with medical protocols and ethics, the risks to anonymity have seemed non-existent. However, such risks would increase if agencies not bound by medical protocols and ethics gained access to the returned syringes.

These risks would also increase if the technical difficulties and costs of testing reduced, as would be expected if political and policy directives led to the procedures becoming more common and requiring less supervision. Furthermore, the centralised funding and more scrupulous record-keeping needed for controlling a strictly one-for-one needle exchange was conducive to forms of intrusive surveillance using marked syringes. The biomedically testable activities of needle exchanges are seen in these incidents of surveillance to have enacted, and become enacted, as a trial of the embedment of the connections between people and objects, objects and viruses, viruses and people, and people with people. These networks linked information about syringes, as objects, to forms of public representation and trust that, in part, constituted people as subjects.

Any increases in distrust could have caused future research to become more difficult, and less financially justifiable. The connections between people, and people with objects, could have carried aspects of distrust that outweighed the aspects of trust. As the logics and methods of NEP-based monitoring consolidated, the uncertainties about peer participation reduced by becoming negotiated and shared among the relatively known NEP stake-holders, while excluding the more unknown IDU networks. As such uncertainties reduced, evidence that supported the peer-professional role was created in the same measuring, monitoring and calculating processes that supported the overall effectiveness of the NEP. Both the NEP and its peer-professionals attained greater capabilities through the 'expert legitimacy' associated with these episodes of unlinked sentinel surveillance (Baker, 1994; Gradwell, 1994). Nonetheless, the absence of a fully standardised longitudinal monitoring programme points to the difficulties inherent in the

403. That this was not known to happen would not stop cautious IDU from taking no chances. The police were at times reputed to charge people with possession of syringes. However, although the legal defence under the NEP amendment to the *Misuse of Drugs Act* was specific, the charge was one of general drug-using paraphernalia, in a separate section. This made it very difficult for peer-professionals to prove whether or not police were regularly charging people with possession of NEP syringes, since the police could, years later, claim the paraphernalia was related to the use of non-injectable drugs. Adding to such difficulties, most IDU would not go to the expense of defending a possession charge, since it would most likely be accompanied by several other charges for which no statutory defence existed (Blacklock, 2003. pers. com.).

framework and expectations entailed by this type of surveillance.

In New Zealand, principles that testing protocols and ethics were founded upon anonymity and of voluntary participation had been publicly acknowledged by expert advisory committees.⁴⁰⁴ These principles were restated in 1990 with the release of the '*New Zealand Strategy On HIV/AIDS*' by the National Council on AIDS (1990a).⁴⁰⁵ The single exception to these principles consisted of unlinked sentinel surveillance. Although these principles mostly addressed issues of individual anonymity and consent, conflicts emerged between an individual's ability to choose not to be tested, the need to maintain trust in health care policy and community wellness care systems,⁴⁰⁶ general principles of community participation and empowerment, and situations such as the non-consensual testing of returned syringes. The guidelines argued strongly against attempts to mass screen entire populations, yet accepted mandatory, anonymous, unlinked mass screening for 'at risk' individuals and groups. This surveillance was not considered unduly costly nor unnecessarily intrusive (National Council on AIDS, 1990a: 50-51).

The guidelines for testing those people or groups believed to be at greater risk emphasised the problems of definitions, identification, enforcement, and subsequent action. These guidelines did not specifically cover the surveillance of syringe returns, nor IDU at needle exchange sites. In a technologically related but culturally different context, the testing of donated human tissue for HIV was considered not only acceptable but mandatory to protect recipients of donated body products.⁴⁰⁷

The guidelines on screening attendees of STD clinics, and on testing anonymous populations stated that:

mandatory testing would act as a disincentive to them and to others. However the anonymous unlinked testing of these people could serve as an indicator of the prevalence of HIV/AIDS in these groups. ... It is sometimes suggested that the ethical and social problems associated with mandatory screening of population groups could be overcome by anonymous screening, as there would then be no means of identifying HIV infected individuals. In this case, the information could only be used for research purposes such as monitoring the progress of the epidemic. For this reason the Medical Research Council Committee on AIDS Research is considering ways of implementing anonymous screening studies to determine HIV prevalence in society.
(National Council on AIDS, 1990a: 51-52)

Such considerations were most likely interrupted when the Health Research Council replaced the Medical Research Council in 1990. However, the latter Council had been deliberating on this issue since 1987 (Malpress, 1987). Such prolonged deliberation with no resolution indicates that the

404. These committees included five versions of the AIDS Taskforce, the AIDS Advisory Committee, the National Council on AIDS, and its subcommittee, the Medical and Scientific subcommittee on AIDS (MASCA).

405. However, the New Zealand Labour Government in its last months, and the following National Governments, refused to be bound by the National Strategy On HIV/AIDS. These governments treated the New Zealand Strategy On HIV/AIDS as an advisory rather than a policy document.

406. For an outline of these important differences, which had been changing since the 1960s, see Grace (1989).

407. An 'unfortunate exception' has existed for HCV. Haemophiliacs and other blood recipients were treated as experimental cases, by being denied screening of essential medical products for two years.

issues involved were thought overly problematic, non-urgent, or better left unresolved. Moreover, this specific problem fitted into a general pattern of health ethics that had developed in Western health care and associated research, as well as in New Zealand, as I will briefly outline.

At the time of the first testing of returned syringes, and later episodes in 1994, the professional frameworks of regulations and best practices for obtaining human tissue samples were unclear, negotiable, and shifting (Grace, 1989). This situation was not unusual. Specific conflicts of principle, such as those erupting at different stages in the development of HIV/AIDS policy, were likely to suddenly highlight long-standing ambiguities and conflicts. The ethical guidelines and conflicts of the health professions have long roots, for instance in the Hippocratic principles of treating promptly, without denying treatment, provided that first and foremost, no harm was likely to result from treatment. However, the development of these principles in New Zealand after the Second World War followed the *Nuremberg Code*, which emerged from the trials of German doctors by a special United States court in 1947.⁴⁰⁸ Nonetheless, the Nuremberg principles were rarely, if ever, cited in New Zealand as being the most significant and strongest expression of the need for informed consent by participants in experiments.

New Zealand perspectives on health ethics have seemed more specifically influenced by the U.S. Public Health Service Tuskegee Experiment (1932-1972), and by New Zealand's 'Unfortunate Experiment' by clinicians at National Woman's Hospital.⁴⁰⁹ The 'unfortunate experiment' altered the public and legal status of medical professionalism.⁴¹⁰ This stream of legislation that followed has appeared to slow or in part reverse a tendency for the guarantees and protections of the Nuremberg codes of informed consent in experiments on humans to be sidelined in favour of the authority and convenience of medical researchers. In consequence, New Zealand ethics committees became far more empowered and central to research during the 1990s and the mid-period of my study of the NEP than had previously been the case.⁴¹¹

408. This trial by a US panel followed the more general Nuremberg trials of Nazi administrators by an International Court (Whitaker, 2003: 234-235). Nonetheless, its findings were presented, and have been interpreted across Western societies as having a timeless validity as a universal ethical principle while, somewhat in contradiction, setting a global legal precedent located in history.

409. See Cartwright (1988), Coney (1988), Bunkle & Coney (1987). This key conflict can be followed in an ongoing debate in the *New Zealand Medical Journal*. See Baird (2005), Tolich & Baldwin (2005), Baird (2004), Williams (2004), Heslop (2004a, 2004b). In this debate, later commentators from within the medical professions have redirected the emphasis from patients' trust in Dr Green onto the handful of whistle-blowers within National Woman's Hospital and the whistle-blowers' inadequacies in not using a professionally acceptable, methodological critique that remained within medical circles. See also later commentary by specialised community health ethicists (Women's Health Action Trust, 2006). Baird (2005, 2004) is the same medical authority who when leading the NZMA in 1987, opposed the NEP legislation on behalf of medical professionals across New Zealand (Baird, 1987). Nonetheless, according to a mainstream media article by McLaughlin (1987: 30), the NZMA had not actually polled its own members beyond those directly in contact with its leadership at the time. This claim did not lead to any lawsuits, and was not retracted. According to anecdotal accounts, the NZMA stance presented to Parliament by Baird was based on a canvas of only its Wellington members (McLaughlin, 1987: 30).

410. The *Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Woman's Hospital and into Other Related Matters* (Cartwright, 1988) into the treatment of living patients by medical professionals provided strong evidence and rationales for legislation changes (Coney, 1988; Bunkle &

These frameworks for tissue sampling without consent remained ambiguous in 2006, according to the *Guidelines for the Use of Human Tissue for Future Unspecified Research Purposes: Discussion Document* which advises that: “There are currently no specific guidelines covering this area. However both researchers and ethics committees have highlighted the need for a consistent approach.” (Ministry of Health, 2006a: 1).⁴¹² In New Zealand in 1987 the only relevant long-established protocol was the *Human Tissue Act* (New Zealand Government, 1964), which governed the collection and usage of organs and tissue samples collected from deceased persons and had little guidance to offer in situations of live donors who might be unknown and might be identified.

In 1990, after being employed by the AIDS TaskForce to co-ordinate IDU aspects of the NEP, Kemp attempted to organise funding and administrative support from Area Health Boards (AHB) for regional health promotion related to HIV/AIDS and IDU outside of urban centres. In his attempt to enrol AHBs in HIV/AIDS prevention work, Kemp designed a plan for the AHBs to be funded through the AIDS TaskForce for regularly testing the returned syringes (Kemp, 1990). This procedure would have established a permanent infrastructure for providing epidemiological data.

Kemp emphasised how such information would allow scarce funds to be better targeted towards the more problematic regions. Kemp did not discuss any protocols over confidentiality, nor anonymity. He did advise that the AHBs should employ: “a resource officer/advisor who would also have the role of empowering local consumers to help form their own AIDS prevention networks” (Kemp, 1990: 10). Such people would presumably collect the returned syringes for testing, but the ownership of the resultant information would seem to be held by the funding officials on the AIDS TaskForce or the regional administrators on the AHBs.⁴¹³ This proposal appears the first and last time that a New Zealand peer-professional advocated such surveillance.

The NEP peer-professionals on the National Council on AIDS (NCA), firstly Wright then Kemp, helped develop protocols about returned syringes. The resulting principles emphasised that

Coney, 1987, Women’s Health Action Trust, 2006). By 1993, such factors had contributed to the *Privacy Act* (New Zealand Government, 1993). In 1994 these concerns influenced the *Health Information Privacy Code* (New Zealand Government, 1994b) and the *Health and Disability Commissioner Act* (New Zealand Government (1994a). These were followed in 1996 by the *Code of Health and Disability Services Consumers’ Rights* (New Zealand Government, 1996a).

411. These ethics committees became provided with their own regulatory and monitoring framework, for instance in the *Operational Standard for Ethics Committees* (Ministry of Health, 2006c). Nonetheless, medical attitudes continued to provide cause for public concern. For instance, the organs from deceased babies had been collected at Green Lane Hospital since the 1950s (RSNZ, 2002) in a matter-of-fact way which was at times casual and at times ‘over-enthusiastic’. This collection provoked revulsion when eventually revealed, since many parents were unaware of such practices and had thought their children had been cremated or buried whole. In another instance, North Health, the Northern Regional Health Authority, claimed that it had a right to prevent disclosure of its protocol of decisionmaking, since this was deemed its ‘intellectual property’ of commercial value. A ruling by the Ombudsman, Michael Elwood (1996, as cited in Women’s Health Action Trust, 2006) was required to clarify for North Health that the data and protocols handled by its ethics committee fell under the disclosure provisions of the *Official Information Act* (1982), rather than just the forms of legislation designed to protect private property. Furthermore, the relevant ethics committees of North Health clearly had not considered the heart collection at Green Lane Hospital to be of significance.

412. *Operational Standard for Ethics Committees* (Ministry of Health, 2006c).

decisions over disclosure needed to minimise any loss of confidence in the overall care system by HIV positive persons and caregivers (National Council on AIDS, 1990a: 48-49). The NCA promoted a precautionary logic, that: “Since compulsion will prejudice gaining the co-operation of those involved, testing to influence behavioural change needs to be done voluntarily and with informed consent” (National Council on AIDS 1990a: 50). Nonetheless, this wording refers to the testing of a set of individuals only, with no mention of any collective community consent.

The National Council on AIDS defined confidentiality and anonymity as applying only to individuals, not directly to groups nor communities. This contrasted with Bruce Burnett’s and the AIDS Support Network stance⁴¹⁴ which included the representation of community concerns along with preventing the control of gay collective identity from falling into the biomedical, individualising methodologies and interests of researchers. The guidelines emphasised links between behaviour change and respectful treatment of members of ‘marginalised groups’. However, issues of ownership and control of surveillance data by communities and networks were not addressed, while issues of community and network distrust were only partially acknowledged and from a perspective that seems already headed in an individualising direction. There seems to have been no discussion by IDU or peers that was equivalent to, or re-articulated, the analyses by gay community organisers about the potential meanings and dangers of HIV testing.⁴¹⁵

The NCA guidelines did not address issues of IDU community participation in disseminating the data they had contributed to. The guidelines offered several arguments against compulsory testing of perceived higher risk people and groups. Yet the same guidelines justified testing without specific consents for research which benefited the mainstream and supposedly unified social collective of the general population. How IDU were marginally positioned as ‘co-operative’ participants, but without consent, in such a unified majority collective, was left unaddressed.

In 1992, the surveillance of returned equipment was supplemented by episodes of sampling the saliva of NEP client volunteers who had given their individual informed consent. The high compliance rates by the IDU clients increased the power and cost effectiveness of the first study in Dunedin (Dickson et al., 1994. See also DIVO, 1991a, 1991b). In the report on the initial testing of

413. Whether IDU would have supported the control of information about their practices being held by AHBs seems uncertain, given the AHB goals of providing abstinence-oriented drug treatment services.

414. Gay representatives valued such tests for removing the necessity to screen blood donors on a basis of sexual orientation, yet did not trust any other than gay representative organisations to keep the recorded results of testing (Bayer & Kirp, 1992: 22-24; AIDS TaskForce, 1985b).

415. Another potential issue involved the expenditure on HIV as compared with HCV monitoring. By 1992 it was known that HIV rates in IDU were consistently low, presumably due largely to the NEP. However, the first study of the rate of new hepatitis C infections among injecting drug users was only released in 2000. This was over a two year period. Previous tests had only recorded prevalence, not incidence. See Brunton (2000). Peer-professionals had co-operated with HIV testing for epidemiological information that benefited the wider population, and received compensatory benefits, in accord with Baker’s concept of exchanging mutual benefits. IDU co-operation over HIV sentinel surveillance might have also been exchanged for funding HCV surveillance. This would have benefited marginalised IDU communities by supporting peer-professional calls for improved NEP arrangements. Why this did not happen is unclear.

returned syringes, saliva methods had been suggested as a potentially more reliable and acceptable method (Baker et al., 1992). Yet the acknowledged benefits of saliva testing do not completely explain why there were no reports of syringe testing after 1994, since the two methods were complementary, not alternatives. The results of the initial saliva tests were more convincing because they could be compared with the results from the non-voluntary samples from the syringe returns testing. Such comparisons ensured greater confidence that the saliva studies were not biased by IDU avoiding the exchanges during the period of the trial. The high compliance rate would have been misleading if there had been any significant avoidance of the survey.⁴¹⁶

Nonetheless, financial concerns provide one feasible reason for not continuing with testing returns. High testing costs would seem unjustifiable once the HIV levels of IDU had been consistently found to be very low. The ethical and methodological difficulties of testing returned syringes may also have become less justifiable as the political urgency and government expenditure on AIDS decreased. However, saliva sampling itself was later replaced by the technique of finger-prick sampling (Kemp et al., 1998), specifically to be comparable with Australian data.⁴¹⁷ This later testing programme was Australian-funded, which removed any choice over methods.

There seem to have been instances of stake-holder agreement, but no clear, publicly stated, general agreement that forms of involuntary syringe testing were desirable policy. The Public Health Commission's Advice to the Minister of Health, in April 1994, recommended that: "periodic anonymous unlinked serum surveys for HIV on blood in returned Needle and Syringe Exchange Programme syringes, though subject to limitations and inaccuracies, are feasible and could show trends" (Public Health Commission, 1994a: 28). Despite such hesitancy over the methodology and benefits of such surveys, the Minister was urged to undertake surveys, every three to five years, of the: "... serology of blood in returned syringes [and] unlinked anonymous surveys of HIV infection in STD/sexual health clinic attendees and injecting drug users" (Public Health Commission, 1994a: 30).⁴¹⁸

The recommendations of the Public Health Commission notwithstanding, the last reported syringe testing occurred in 1994, with no reported reason for the absence of later reports, or for the recommended protocol being abandoned. I found no references to any public discourse about surveys of anonymous, non-linked samples of human tissue in returned syringes. Nonetheless, in the 1994 returned syringe study the authors note: "To reduce the potential for alarm and

416. A methodology for providing the greatest comparative power would minimise IDU abilities to avoid making returns during the collection period. This could be achieved by not informing NEP clients about any testing. Such a methodology would destroy IDU trust in the NEP and be far more costly than useful.

417. In the early 1990s there were problems in gaining HCV prevalence data from small blood samples, and saliva samples. These problems had been resolved by the mid-1990s, but funding for seroprevalence surveillance and incidence studies was not available. New Zealand researchers therefore used Australian funding and standard methods when opportunities arose, according to Brunton (2005. pers. com.), Barnett (2004. pers. com.).

418. Serology refers to the study of blood serum for its antibody content. Seroprevalence refers to anything measured in blood, such as viruses.

misunderstanding about the purposes of the study, all known IDU groups were consulted prior to the start of the study” (Walker, Brady, & Baker, 1994: 7). Nonetheless, conflicts and debate emerged over the use of samples taken at STD clinics for purposes not related to the reason for taking the sample, and over the Guthrie database of blood samples from new-born babies.⁴¹⁹ In the case of NEP syringes, policy statements have only referred to the possibility of monitoring, along with the desirability that such surveillance be anonymous. A widespread yet unvoiced reluctance to continue the practice, or to refer to the practice, seems apparent, despite some aspects of returns testing seeming useful.

If consent and control problems had been recognised, yet had not been considered significant in terms of consulting and negotiating, then questions arise over the protections of the: “rights and dignity of population groups directly affected by HIV/AIDS” (National Council on AIDS, 1990a: 3). These are the general principles of the *Ottawa Charter* (WHO 1986), the World Health Organisation’s Global Programme on AIDS, and the World Health Assembly Resolution 41.24, which New Zealand cosponsored (National Council on AIDS, 1990a: 1-2). This lack of discussion, let alone guarantees or protocols, seems indicative of a social perspective on surveillance that ignored or even conflicted with the perspectives and interests of an IDU population considered directly at risk of transmitting HIV/AIDS. Although syringes and IDU counted, particularly by producing records of numbers, the protocols of biomedical and epidemiological have not counted, at least in the positive numbers. These protocols seem to have counted for zero, unless their actual absence makes a negative account necessary.

3 Surveillance and feedback within complex network patterns

A professional level of epidemiological surveillance of IDU and their practices had become possible due to the closer connections and the new forms of access made possible through the NEP. Nonetheless, such surveillance and evaluations were considered to potentially lower the rates of voluntary participation by IDU, since IDU had reason to distrust and avoid any surveillance that they could not control. Yet IDU networks had survived and were shaped through forms of skill in manipulating the evaluations of pharmacists, doctors, and police, while seeking out trusted peer connections.

Trust and distrust have been crucial for IDU. Yet the surveys that sampled volunteers relied in turn on widespread trust of an IDU kind, because high compliance rates were needed for the findings to be methodologically convincing. Those carrying out the saliva sampling survey in Dunedin had been concerned about the uncertain propensity of IDU to participate, and were relieved when

419. See Paterson (1996: 40-41), Johnston (2004), Auckland Women's Health Council (2004), CASONZ (1992).

excellent response rates were obtained (DIVO, 1991a, 1991b; Dickson et al, 1994). Low compliance would have diminished the representational validity of the sampling methods, while suggesting that unaccounted for factors were significant, thereby reducing the accuracy, relevance, and predictive capabilities of such surveys. Low capabilities also made survey-based research proposals more difficult to justify on cost-benefit grounds. For all these reasons, trust, distrust, and participation rates influenced the capabilities for evaluating the NEP.

Evaluation of the NEP was considered necessary, yet not through direct individual surveillance. This seemed dangerously close to 'working against' the people and groups whose participation was needed. The primary desired outcome for sexually active people was a motivation change that led to the behavioural change of using condoms, which were legal and readily available. Health promotion policy readily focused on how distrust would lead to ineffective or worsened health outcomes through non-compliance. In the case of IDU, safer technologies, environments, and practices of syringe use were desired alongside motivation changes towards greater control. The motivation change aspects were similar, but the legal aspects of the technologies involved created differences and difficulties. Unlike condoms, the syringes supplied and promoted were only semi-legal. They were illegal and could become prosecution evidence if intended for any illicit purpose such as drug injection. The licit possession of syringes became both connected and differentiated from the illicit possession of drugs, due to the NEP legislation.

The testing of returned syringes between 1989 and 1994 benefited IDU and needle exchanges in several important ways, while not seeming harmful. Involuntary syringe surveys complemented rather than competed with the voluntary participation of IDU clients in the surveys that measured HIV prevalence, IDU motivation, and injecting practices. Despite differences in how the procedures positioned IDU, the syringe, saliva, and finger-prick forms of monitoring relied increasingly on the premises, systems, and participation of peer-professionals working in needle exchange outlets. The saliva and finger-prick samples could certainly be taken at pharmacy exchange outlets, but the logistics of interviewing amid more 'normal' surroundings were easier to arrange at a peer exchange outlet.

These types of surveillance were intended to measure changes in the activities of viruses and the activities of the NEP. For some researchers, surveillance appeared primarily motivated by epidemiological goals (Dickson, 2004. pers. com.). For others, the goals appeared both epidemiological and administrative.⁴²⁰ For the peer-professionals, the surveillance through syringe testing helped to consolidate their autonomy, their representation of IDU, and their ties of trust joining IDU to those overseeing the NEP.

The provision and return of syringes provided direct health benefits that were demonstrated by

420. For instance Baker (1994, 1989, 1988c, 1987c), Walker, Brady, & Baker (1994), Baker et al. (1992), Kemp (1990).

rapid and continuing decreases in HIV prevalence among IDU. The circulation of syringes also provided cost-effective ways of measuring attitudes of compliance and trust among IDU. Evaluations of gay-focused health promotion have seemed more community-based and epidemiological than equipment-based. By contrast, the NEP's emphasis on measurements and evaluation shifted from specifically funded research about individual IDU practices, towards systematised hierarchal reporting built into the NEP mechanisms. As quantities of such information increased, the quality remained limited by funding caps and contractual disconnections between Department of Health managers and local co-ordinators. The Department managers did not receive empirical information relevant to specific problems through their formal channels, which presumably increased the influence of any informal connections.⁴²¹

The surveillance of syringes and NEP clients increased the representativeness and capabilities of the peer exchanges, and accordingly, increased the resources indirectly available to IDU. Yet some particular forms of testing reduced or threatened individual the agency of IDU in a different way. The potential autonomy of IDU in egalitarian networks became reduced because their embedded knowledges about drugs, injection, and fellow IDU became more categorised and commodified. The pervasively distributed, local information started to be handled and represented by a restricted, specialised type of 'peer expertise'. This peer-professionalism became acknowledged as effective, efficient, and trustworthy because its monitoring capabilities connected and brought together in one package the previously separated parts of drug-using networks. Such surveillance acted across cultural boundaries of inclusion and exclusion, across the geographical sites and places of syringe movements, across the mixed motivations of IDU, and across the changes in populations of viruses and antibodies. These centralising aspects seem inherently problematic for agencies that argue and produce information according to a single professional or official standard of evidence, while exercising representation on behalf of others who have no public voice to insist on their diversity and uniqueness. Yet, instances of peer group collapse, such as CIVDURG, illustrate the problems of unprofessional peer activity that relies overmuch on evading common standards of prudence and trust.

421. Correspondence between the NEP co-ordinator and the Christchurch District Advisory Pharmacist (Lewis, 1988) illustrates problems of obtaining scientific information rather than speculation over the content and rates of returned syringes. The District Advisory Pharmacist systematically opened return containers and hand counted the individual syringe numbers, since the NEP Management Plan had made no provision for such monitoring. Hand counting was contrary to best practice and involved significant risks of needle stick injury and HCV transmission. The District Advisory Pharmacist was: "in no doubt that it is unrealistic to ask the pharmacist to count or even guess at the number of syringes" (Lewis, 1988). Another early problem involved poor quality syringes that caused vascular damage to IDU. Mr Pollard arranged for an engineer to take micro-photos of a sample of the supplied needle tips, which he supplied to the NEP co-ordinator. He reported: "The degree of barbing on both is sufficient to confirm such statements [by IDU complainants] as "there was meat on the end of it" ... [I] trust that your officers will be requested to take rapid action to rectify a supplier's fault which, to say the least, is surprising in a major contract (Pollard, 1988). The Department of Health had relied on its contract with the manufacturer and importer for quality control of this health product. Mr Pollard had sold syringes illicitly before joining the NEP. He was distressed at being forced to sell harmful products instead of the high quality syringes he had supplied to Christchurch IDU at cheaper prices than permitted by the NEP regulations.

The incidents of testing reinforced the regular monitoring that connected IDU with peers, but in different ways according to the shape of the connections involved. Even though IDU range in their capabilities, from people desperately wanting withdrawal treatment to those holding down professional jobs and controlling their careers, participating in the testing and monitoring of other IDU was a completely different sort of activity and a connection that only made sense in a new type of officially-approved occupational environment.

Such connections and resulting knowledges contributed to IDU and peers becoming differently represented. The NEP allowed its IDU client populations to be directly measured and recorded in terms of the numbers of visitors and syringes. These populations were a large fraction of the total IDU population.⁴²² The measuring activity blended much of the variation of IDU into a single client population as a totalising effect. These systemic ways of measuring did not require active participation by IDU. The exclusion of IDU agency reduced political problems of public and official acceptability at the crucial stage when legislation change required the enrolment of supportive factors.

It became easier for peer-professionals to represent an unproblematic, manageable, 'trustworthy' IDU community. Nonetheless, it was the solid infrastructure and alliance building of the peer-professionals as representatives and long-term stake-holders, rather than the less predictable actuality of IDU and non-professional network practices, that was being represented. As in the formation of the IV League,: "Politicians are uneasy about individuals and groups ... they are much happier if an organisation can be presented ..." (Baker, 2002. pers. com.). IDU as peers became represented as more known, and more trusted, as participants in health policy and programmes. The NEP peers provided greater access to IDU through such developments, while simultaneously, sterile syringes were supplied and used syringes removed from risk situations.

It is important to attend to what was being represented. Actor-network approaches draw attention to how the relocation of meaningful objects often involves significant translations and re-representations. We have seen how syringes moved from place to place while altering in meaning to participants and policy-makers. Such representations were not only enacted by labelled lists of NEP goals, methods, and data; but also by how syringe information was referred to in specific contexts, and by whom it was moved about. The difficulties of representation increased in significance according to the work of connecting and disconnecting the information attached to the objects that defined individuals as lay or professional, as criminals or health promoters or law enforcers.⁴²³ Representation has been seen in how the understandings of participants 'carried' and helped co-ordinate other elements and people in these networks. The symbolism and potentials for

422. It would not have been 100% because some IDU do not go to needle exchanges (Jang, 2005. pers. com.).

423. See Moore (2004), Gomart (2002a, 2002b), Gomart & Hennion (1999), Harper (1997), Callon (1999, 1991).

action of the syringes carried expectations of how living people and viruses, with 'their' filters, sterile water and drugs, might or should behave. Representations contributed to the networks within which information was interpreted, and which were effected as a result. Syringes represented peers and IDU in some contexts, whereas peers who filled out syringe records, and IDU who took part in surveys, represented syringes in other contexts.⁴²⁴ That is not to say they were identical or even equivalent, but rather that they modified each other, and in so doing, modified their extending networks. These entities and activities have been usefully understood as hybrid networks.⁴²⁵

I point out how syringes have, as hybrids, acted simultaneously as objects, information and representations which connected IDU bodies to drugs as co-constituents of networks. Syringes, as a mass-produced, identical, commercial commodity contrasted with both bodies and drugs in seeming to be less complex, less value-laden, and more 'pure'. As these sterile syringes were used they moved to an impure form, which carried bits of bodies, retained traces of drugs, accreted information in official records, and exuded representation. If one assumes that 'pure' information cannot exist in any active way outside of its physical embedment in locations, objects, and interactions, then there is nowhere else for much of such representation to be carried, apart from these embodied and 'positioned' circulations of syringes.

In the hybrid syringe mechanism I describe, the changes in these circulations, for instance of physical movement and network positioning, consequently entailed changes in the representational activities. Changes in the control of movements and positionings, for instance of syringes and peer-professionals, influenced how network elements were re-represented as a constructed effect by other network elements. Shifts in the methods of HIV sampling, and in the numbers of syringes returned, caused peer-professionals, along with IDU, to interact differently with the more distant actants that constituted their network. The consequent difficulty lies in selecting the markers or measures for the story of the significance of how things changed empirically, or how change was empirically resisted.

An evaluation of a hybrid environment needs to take all the contributing entities and processes into account, partly by conceptually identifying and naming them, while also following how their mechanisms of interaction have actually worked empirically. This is why both the interests of participants and the activities of objects have been combined in my descriptive explanations, and why biomedical testing is an appropriate area for following the workings of such a combination. Returned syringes, as objects, represented IDU by being considered more trustworthy than the users themselves. The results of such testing supported the initial NEP and helped it to consolidate.

424. See Latour (2004, 1999b, 1999c, 1993, 1987) for discussion of interests and consequences of constructed conventional 'modernist' binarisms whereby 'nature' is used to explain the 'social' and the 'social' to explain 'nature'.

425. See Chapter 1, 2, 3, and Appendix 9, particularly 9.5 for discussion of hybridity.

The HIV prevalence that was reported did not justify changes to the NEP, yet was sufficient to not induce complacency, given the explosive increases in HIV observed among overseas IDU, as described in Chapter 3 and 5. The testing of returned syringes seemed less of a gamble⁴²⁶ than trusting IDU self-reports, or trusting peer-professional influence over IDU.

Self-reported information from anonymous IDU volunteers came to be considered more cost-effective and more generating of trust than testing returned syringes. This was because IDU proved to be compliant with 'their' peer-professionals. Approvals from peer-professional gatekeepers were needed to provide opportunities for testing and to enable better evaluation of the programme. Yet each time such approval was obtained, the IDU in contact with needle exchanges, and the peers who represented them, became more trusted. This meant they became collectively more competent, better resourced, and of higher status through being presented as 'trust-worthy'. Eventually, as these episodes and relationships accumulated and became more expectable, IDU and peer-professionals acquired new opportunities to monitor drug treatment agencies. Peer control of syringe returns and motivation change both required, and generated, trust and representation.

As well as both IDU and peers being represented by networks of syringes, statistics, and stories, peer-professionals also claimed to represent IDU through organisations. The forms of connection that increased trust and representative voices also contributed to representations of needle exchange peers as different from IDU. IDU had been characterised as incapable of self-organisation, and differentiated from gay-dominated groups such as the NZAF. Some researchers have commented that the systemic controls involved in medicalising processes (White, 2002: 40-52) are necessarily connected to various social controls involved in marginalising and criminalising processes.⁴²⁷

Others have noted that a lack of IDU self-organisation has been a rational reaction to IDU environments. These commentators emphasised that minimal self-organisation is not a determinist law applying to hedonistic, self-medicating, or addictive practices of chemically modified physiology. For instance, Price (1992) has offered examples of groups that had been labelled as unorganisable, yet managed to mobilise around mutual interests and group concerns and so to defy obstacles that had made them seem powerless to outsiders, and to themselves (143). Price supported his perspective by offering an account of an AIDS education group that represented IDU in Baltimore. Members of this peer group reported that in responding to the challenges presented by HIV/AIDS, the barriers to IDU self-organisation were surmountable, yet only if ex-users who promoted abstinence ideologies were prevented from participating (Price, 1992: 143-144).

Price's account in 1992 of the experiences of the Baltimore peer group are not surprising. Due to harm reduction principles being formally legitimised, for instance in the *Ottawa Charter* principles,

426. For discussion of relationships between trust and gambling, see Sztompka (1999).

427. See, for example, Jenks (2003), Garland (2001, 1999), Haggerty (2001), Agger (1998: 140, 172), Muir & Ruggiero (1994), Becker (1964). See also 'Governmentality' literature in general.

together with the empirical actualities of criminal and health enterprises, needle exchanges could only work in ways that followed the actually existing drug markets. Changes towards health and wellness could influence IDU through example and environment, but could not enforce motivation and behavioural change without destroying the peer-professional types of credibility, along with the viability of the NEP.

What is also apparent is that apart from being represented by having stories told about them, IDU had, to a limited extent, began a new way of exerting formal representation outside of their resistance tactics in court and treatment environments. Such representation was presented in submissions to select committees on health legislation and government programmes, as well as in letters to the public needle exchange magazines produced by the peer groups. Such representation was also expressed in accounts of the injustices and inequalities suffered by would-be consumers of addiction treatment services to which access had been denied, and in negotiations with researchers. Most of this representation has been facilitated or directly initiated, by peer activities.

The representation of IDU emerged from the professional effectiveness, efficiency, and sustainability of the peer component of the NEP. Such professionalism risked distancing 'peer-professionals' from the drug markets and social networks around which the 'demand side' of IDU worlds have been organised. However, if it were not for drug use being criminalised, peer-professionals would not be so necessary, nor so scarce, nor in consequence develop such a degree of influence and significance. IDU, being autonomous and ineradicable, represent peer-professional capabilities perhaps more than peer-professionals represent IDU. They diverge, and modify each other, yet each is constituted as each other's resource, provided that HIV is present to activate their binary coupling while destabilising the simply dualistic aspects. Although synergies between peer and professionalism are seen, excess distance between them causes problems for the representation and trust which influence the motivation change and the return rates. Whether peers can adequately represent themselves in conflicts with more professional segments of the NEP environment remains a critical issue for on-going study. Provided injectable drugs and syringes remain illegal, the network of conditions within which used syringes are returned will provide a key focus for such studies.

High return rates have indicated that most IDU have continued to trust the NEP's peer-professionalism. Yet, a significant percentage of IDU have not returned every syringe, despite the financial incentives. This has, presumably, been due to convenience aspects, combined with a fear of being taken into custody on a holding charge. However, it would be technically and legally possible for used or returned syringes to be analysed and entered into a database by forensic scientists at the ESR. Such actions would be in accord with policies and laws designed to expand the DNA databases.

Early in the NEP, informal understandings led to a precautionary approach in which:

It is recommended that police not [orig.] be involved in day to day administration of the scheme or have access to local data collected as a result of its operation. ... The recommendation that police not be closely involved with the operation of this scheme is a carefully considered policy. This is based on extensive feedback from users and ex-users whose major fear is that the exchange scheme will be used to assist police drug surveillance work. To allay this fear it is considered essential to maintain a visible separation between this scheme and drug enforcement. (Baker, 1987c: 17)

When NEP surveillance information became available it was gathered and deployed according to general health goals and logics, yet also to facilitate the administration, and to provide reassurance for crucial NEP stake-holders, particularly the police. Yet IDU also required reassurance that the police were not being helped to arrest them, and their peers, by means of the NEP's information. Problems of IDU trust could readily emerge in cross-agency integration, where health agencies 'share' evaluation data with police.

The details of information sharing between health and policing agencies have not been publicised, yet this seems cause for concern rather than complacency, since the increase in such sharing has been publicly promoted as a general and pervasive output intended to enhance the integration and efficiency of government.⁴²⁸ Since IDU are not able to ascertain where such sharing stops, they would seem to require forms of reassurance that their interests were not compromised by taking part in surveys which provided information that police would use in more effective harassment and prosecution of their peers. Yet since IDU do not trust state agencies and professionals, the peer-professionals who have made these surveys possible would seem appropriately positioned to offer more rigorous guarantees. However, they could not offer any guarantees based on evidence without being able to follow and scrutinise that information as it moves to higher-levels. Yet it seems likely that police would object to such scrutiny, showing how that which was workable when divided and siloed would be far more difficult and probably unworkable when seamlessly joined.

How consents and control might transform over such transfers of information leads to questions of whether the degree of informed consent in testing returned syringes has been appropriate and adequate. Trust and distrust seem inherently involved because if information carries representations of oneself or a group, even though each individual is anonymous, one's or one's group's public aspect becomes a story told by others, and less of one's own voice. This would seem overpowering rather than empowering.⁴²⁹

The sentinel surveillance of seroprevalence and programme evaluation have been seen to connect

428. It might be argued, however that such goals and methods are intended to enhance governance rather than government. This question, posed in the midst of such changes, cannot be argued further without comparative information from a range of empirical case studies.

429. Except in the Foucauldian sense of becoming assimilated into one's own production of identity.

criminal IDU worlds to the professional and bureaucratic worlds of state agencies. Since distrust is indicated to be pervasive, to resist surveillance, and to be magnified by the prospect of surveillance, the exchanges of surveillance with health benefits must have involved increases in trust. This environment positioned peer representatives as an essential connective element that guaranteed IDU participation in such surveillance, as well as in their overt, primary work in changing motivations. However, creative distrust has been required as an essential focus for motivation change towards safer using, because, desperate situations exempted, syringe sharing takes place between people whose private relations or moral standing have motivated them to trust each other too much (Plumridge & Chetwynd, 1998).

AIDS activists and community organisers have publicly challenged some conventional frameworks of understanding, preventing, and treating the personal, cultural, and political consequences of HIV transmission. For example, an ACT UP spokesperson has emphasised that “AIDS is not what it appears to be ... AIDS is a test [my emphasis] of who we are as a people [my emphasis]” (Russo, 1991: 301-302). Michael Brown has explored such insights geographically, insisting on “*constantly rethinking where citizenship really occurs* [orig. it.] rather than automatically jettisoning state-centred spaces for those associated with “civil society”” (1997: 119).

HCV intensified and extended such trials of the interactions where planning-centred activities of state interact by means of personal activity with the distributed goals and resistances of a civil society. Furthermore, the crucial objects of interaction together with an actor-network approach to explanatory accounts, have been seen to be threaded by a situated biomedical expertise in technoscience⁴³⁰ practices that include the practices and capabilities of seroprevalence and forensic testing. Such expertise has been seen to mediate and be mediated by interactive links of trust and distrust amongst key identities and interests, while informing and configuring alliances that intersect managerial and health professional forms of authority, in practices of governance by means of intermediaries.

Factors including financial costs, lack of precision, uncertain validity, and requirements to adhere to overseas standards, have all suggested that returned syringes were not being tested after 1994. However, the episodes of testing provided useful information along with certain costs, while being increasingly technologically feasible, while the analysis of costs from the NEP’s founding period seems increasingly overwritten by more recent agendas in the policy arena. There are no formal guarantees that syringe testing would not happen again, nor are there peer-professional protocols to control any such reoccurrence.⁴³¹

430. See Haraway (1991a, 1991b, 1997: 4, 2000a, 2000b), Latour (1987: Ch. 4).

431. It might have been argued that such precautions would alarm any ‘naive’ NEP clients, but such an argument does not appear in any records. If the absence of discussion is explained in such a fashion, then by implication, instances of syringe testing might have continued and also not appeared in any records. In general, secrecy of any sort seems likely to breed distrust, although it seems that people can learn to trust in a ‘balance of distrust’.

I argue that these considerations outline the overall configuration and muted articulation of an ‘internal ethic’ that specifically inheres to needle exchange goals of safer using environments and IDU motivation change. According to this ethic; if NEP activities are justified due to reducing harms in both IDU and general non-IDU communities; and if such protection is dependent on maintaining trust relations between state agencies and IDU via IDU peer representatives; then no matter how convenient for governance, enforcement, and evaluation purposes; nobody should permit the ongoing maintenance of trust to be undermined by the non-disclosure of surveillance. This ethic has emerged immanently, rather than intruded ‘from elsewhere’.

The returning of used syringes promoted the sustainability of the NEP by removing a potential cause for public and political opposition. However, the returning of syringes remained a matter of public accountability to state agencies, rather than a private need for which individual IDU could be made responsible. This meant the costs and arrangements for motivating IDU to bring returns, and disposing of those returns, aggregated into large financial numbers and large political problems. The logics of returns promoted centralised organising, where IDU and peer representation was carried by syringes as objects, and by syringes as a system of logistics. By making it possible for IDU bodies to be acted on at a distance, the supply and return of syringes has intensified relationships of trust and distrust.⁴³² Returned syringes altered such relationships according to how information, syringes, and bodies were used and circulated in combination and collaboration. The logistics of syringe movements, when combined with biomedical testing technologies, represented forms of peer-professional control and accountability. Distrust and trust also explain how precariousness and silences may be notable in some aspects of needle exchange environments. Aspects of distrust and trust found in syringe movements not only clarify the shaping and stabilising processes described previously, but also indicate potential ‘turning points’ for future changes.

This chapter has explored the biomedical testing and monitoring of syringes in relation to the commercial infrastructure of the NEP, and its reconfiguration of relations of representation between IDU and peer-professionals. In this outline of an ethos of the NEP, or at least a significant strand in its account, I have specified and consolidated key aspects of trials of biomedical authority, research, trust, which I suggest, consolidate into an ethic of harm reduction. I proceed in the following chapter to explore an interwoven strand consisting of the development of an infrastructural configuration. Syringes became commercialised as a ‘commodity of deviance’, while peers became professionalised as health actors who ‘specialised in deviance’. As the

432. How and to what degree IDU might be particularly concerned about such issues, as individuals or groups or networks, seems difficult to evaluate. Surveys of client attitudes to peer exchanges have indicated high satisfaction and little desire for changes apart from those already pursued by peers (Aitken, 2002). However, there are no safe means for IDU to discuss issues nationally, except through peer-professional representation. Who would want to confuse health promotion messages and provoke IDU distrust by raising contentious issues of representation?

transport of syringes developed, various cultural motivations, regulations, and financial incentives increased in significance. Yet as in the ‘trials of trust’ I have described, the commercial infrastructure involved antagonisms amid the regional administration and the occupational accountabilities. I will describe how these antagonisms increased the hybrid, peer-professional standards and capabilities of the NEP.

Sustainability: Representation through commercial practices

Simplexity is the tendency of simple rules to emerge from underlying disorder and complexity, in systems whose large-scale structure is independent of the fine details of their substructure. Complicity is the tendency of interacting systems to coevolve in a manner that changes both, leading to a growth of complexity from simple beginnings ... unpredictable in detail, but whose general course is comprehensible and foreseeable.

(*The Collapse of Chaos*. Jack Cohen & Ian Stewart, 1995: 3)

In the previous chapters I described the founding of the NEP in terms of a peer, official, and professional co-adaptation brought about by the intensifications and shifts that followed the defining of HIV/AIDS as an urgent political and public health problem. I followed the ways in which the work practices that I term peer-professional, along with goals of surveillance and representation, became partially separated from specifically IDU, official, and professional activities. I outlined the formation of a hybrid niche environment. This was walled off, in a knotted re-configuration of institutional boundary 'lines' that delineated the conventional institutions of crime and health. Nonetheless, my initial focus on how the NEP was shaped as an occupational space did not address how certain founding arrangements lasted for over twenty years while others did not. Since these stabilities were distributed across key incidents, durations, and distances, they were only sporadically touched on when tracing the more consistently stranded details of temporal, eventful developments in Section 2 of this thesis. Furthermore, my starting focus on the early periods of the NEP's shaping did not adequately explore the continuing construction of a policy consensus, nor the limitations on any empowerment of marginalised groups, nor the co-ordination and the shifts of marginalised peer-professionals closer to elite policy communities.⁴³³ Accounting for such dynamic, unstable aspects has required a further stage of analytical tightening and integrating in this chapter.

As the NEP developed and consolidated it did so in particular places, partly following and partly resisting its founding principle of national coverage. I briefly referred to this aspect in earlier chapters, but here I account for these 'locational processes' in more empirical detail, utilising both geographical and actor-network approaches. I found that the national systems of professions, legislation, policy, and fixed prices were important, but too dislocated to explain much about change and stability. Instead, I will draw attention to the linkages and gaps between secretive sites of injection, information-producing NEP outlets, contestable regional identities, places considered deserving of financial expenditure, and various 'centres of calculations' (Latour, 1987: 229) that informed the national NEP policy. Significantly, while four of the five initial urban peer groups

433. See Brown (1999), Lindberg & McMorland (1996), and Plumridge & Chetwynd (1994) for previously theorised accounts of these issues in New Zealand contexts. See Chapter 2 for Australian and generalised accounts of HIV/AIDS policy change that influenced New Zealand NEP developments.

survived, all of the four state agency bodies that successively co-ordinated the NEP had been disestablished by 1995. Yet in 1995, Needle Exchange New Zealand (NENZ) was incorporated as the federation of autonomous peer groups, then continued to survive as a national co-ordinating body for over a decade. NENZ, accordingly, seems to exemplify stability. Nonetheless, the autonomy and centralisation of NENZ developed in conditions and episodes of instability. How did the alternative forms of national co-ordination and capabilities come to not work when NENZ did?

I argue that the NEP's significant places and conflicts over policy became linked by means of commercial and managerial practices into network effects that I account for as a fourth cycle of corporatising and professionalising events. The activity of this cycle centred on the objects, movements, difficulties, goals, practices, and alternatives from which NENZ was constituted. NENZ was founded on goals of achieving greater efficiencies, competencies, and representation for its member peer groups. This set of goals was planned and then consolidated in a commercial, corporatised direction, while retaining IDU values of egalitarianism alongside health advocacy values of empowerment. The consequent increase in the commercial professionalism of the NEP both aided and compromised its health professionalism, making some shapes of organising and logics⁴³⁴ more stable or otherwise sustainable than others. In 2003 the Public Health Service Handbook (Public Health Service, 2003: 78-82), depicted the NEP as a large, well-run, prestigious programme. However, such stability, expansion, and status did not 'just happen', and certainly not smoothly. Though NENZ survived, its path has at times been highly uncertain. NENZ has been an effect interwoven from the national, regional, and urban systems of transporting syringes that developed as a layering of, but not a separation from, the representation of the member peer groups and the IDU clients. At times the transport and representation came into conflict.

Some peer exchanges that IDU had attempted to organise were never funded and so never eventuated,⁴³⁵ CIVDURG eventually collapsed, and other peer groups experienced cycles of crises and resuscitations. Some peer-professionals wanted to increase the numbers of local peer exchanges by incrementally expanding beyond urban centres, whereas others wanted to consolidate the NEP's mid-level administrative infrastructure into regional blocs that 'covered' rural areas at an official level, instead of 'on the ground'. Nonetheless, any prospective mid-level administrative 'centres' for the NEP that appeared, disappeared just as rapidly, as did the Area Health Boards (Kemp, 1990). Swings between regional and national centres, and between high and mid-level official agencies such as Regional Health Authorities, the Public Health Commission, the Health Funding Authority, and the Ministry of Health, also created administrative disjunctures, which encouraged administrative logics to rely more on market processes than on longer-term planning.

434. Such organising logics changed according to a participant's position in the health sector between IDU networks and official hierarchies, and in the degree of shelter from a neo-liberal policy environment.

435. This illustrates how a user-pays system could only assist, not totally support a peer exchange outlet.

The available records indicate that the NEP's goals were consistent despite their division, while its workable practices were often opportunistic. These linked wide and long term differences express several distinct aspects of hybridity. Yet these goals and practices were strategised towards trials of strength and workability, and adapted at particular moments as a result of such trials, in ways that, like a personal career, were neither predetermined, nor purely sprung from chance. All of the alternative proposals for administrative territories, specialisations of practice, and types of regulations, made sense. Yet each made additional sense as described from particular perspectives and positionings that outline different variations of a peer-professional situational logic.

The NEP's commercial and health aspects have contributed to several key turning points,⁴³⁶ even after the crucial initial choice of a model for delivering services based on commercial pharmacy practices (Robinson, 1990: 26). First was the emergence of the peer groups that later federated into NENZ. One turning point in 1995 involved peer professionals selecting and employing the NEP co-ordinator. Another in 2001 featured the narrow avoidance of a nation-wide strike by the peer groups. A further cusp in the NEP's trajectory arrived in 2002 with the publication of an external review (Aitken, 2002), independent of the Ministry's gate-keeping and influence. This review evaluated the federated peer groups as being uniquely responsible for an extremely high level of service delivery.⁴³⁷ At any of these cusps, things might have developed differently, raising the question of whether the survival of NENZ has been purely due to chance, or to any selective conditions in its environment of mechanisms, or to other processes and entities that might explain patterns of events.

I have not attempted to offer a detailed description of the network of urban exchanges,⁴³⁸ since the complexity of the individual character of the existing groups, in their local environments, cannot be adequately handled here. Instead, I have condensed selected events and periods into a generalised, more abstract account. This story-telling method of integrating path-dependent factors and network conditions has been discussed in Chapters 2 and 3.⁴³⁹ I first developed an eventful model that

436. These 'points' did not cause things to happen, rather, they were produced as notable events from network effects, path dependencies and cyclic effects.

437. A later turning point in 2004, most likely of great significance, has involved the shift from obligatory user-pays funding to state funding of a voluntary free 'one-for-one' scheme in 2004. Although still being adjusted in terms of logistics and record-keeping, this innovation has begun to alter the NEP framework and mechanisms which have evolved and consolidated over 16 years. For instance, up-to-date record-keeping becomes more necessary, yet perhaps resisted at local levels. Pharmacists and peer groups are no longer paid directly by IDU clients, but by a centralised disbursement system, which requires greater professionalism by its users, yet creates greater vulnerabilities to local agency. A concurrent legislative shift from possessor to police in the onus of proof for syringe possession has not necessarily constituted a turning point because there is no regular record of the police. IDU, or defence lawyers changing their behaviour. However, there has been a single instance in 2007 of a Dunedin Court of such charges being dismissed by a Judge, on expert advice from the local peer group and NENZ, leading to expressions of interest from defence lawyers (Henderson, 2007. pers. com.)

438. This is partly because of the time requirements in tracing the missing information about peer groups that never happened. I found references to several, though only one in the Motueka district as a detailed proposal. I suspect there could be many more.

439. And also discussed in Appendix 9. In brief, historical sequences and interactional structures offer different perspectives on characteristics, direct causes, and selective conditions, yet to explain persistent patterns of activity, a mechanism or a model, expressed through a narrative, is required. A model describes the named objects and

specified how the stability of the hybrid NEP infrastructure was produced from peer group autonomy, within a national federation, combined with national aspects of commercialising and professionalising. I then attempted to describe the activity of this model in terms of mechanisms and sequential effects that explained the manner and consequences of different regional administrative blocs being proposed but not eventuating.

My explanation develops in four steps. In the first I will outline the conditions of unaddressed needs of central, high-level co-ordination and of national coverage by the peer-based services. Section 2 begins with the establishment of NENZ as a body that was expected to further develop the NEP's commercial expertise, along with the representation of its peer member groups, at a national level. This has been significant since its founding members intended NENZ to enhance their autonomy, while not being limited to merely facilitating their regional expertise. Section 3 lays out the development of conflicts between NENZ and the Ministry of Health, particularly over the goals of increasing the services and funding to reduce hepatitis C transmission. I will describe how attempts to provide free syringes outside of official support frameworks had been a founding goal of NEP peer-professionals. I will also describe how this goal reduced the capabilities of the NEP by adding to the difficulties of working alongside pharmacists, by increasing conflicts between particular regional groups and NENZ, and by directly involving health officials and peer-professionals in each other's territories. I will show in section 4 that although such 'partnerships' involved a degree of consensus, or shared goals, they are better characterised by the trials of strength and capabilities as described in the previous four sections. These trials involved antagonisms between health professions and governments over health budgets, as well as conflicts between criminal injecting practices and state officials over the enforcement of prohibition legislation.

1 Multiplicity and fragments: Market networks and central incoherence

In 1987, the NEP planners needed to provide more reliable and wider-spread services than the illicit pharmacy syringe supply system that had sprung up from the ground. The planners promoted a model that combined national direction by Department officials, funding through 'user-pays', and implementation through contractual market arrangements. The Department was not to have any role in the logistics of supplying syringe packs, but would instead: "function in a regulatory way to ensure that specifications meet the demands of the scheme as a disease control measure and that

identities of interactivity from the outside, a mechanism describes the shaped agencies involved in the exercise of energies, entropy, and assemblages from the inside, following the opportunities and constraints as they influence one of many futures to become history. Such a narrated model can be tested and improved through application to unique events; in the process revealing connections and patterns. Such narrated accounts are interactional in that a reader could not make sense of it without drawing on their own accounts, which are not totally the same, nor totally different. See Chapter 2 and 3.

these specifications are being complied with" (Baker, 1988b). The planners did not want the expense and other costs of direction by officials to compromise a simple exchange of syringes for cash. User-pays transactions separated the funding needs of the moment from the potential systems of bureaucratic governance, while being an approved practice of the IDU, GPs, and pharmacists who all ran private businesses of different types.

When the NEP was introduced it featured no continuous bureaucratic or political direction. Yet it required consents of various types from a political environment that demanded accountability, generally through extensive and rigid regulation when illicit drugs and criminalised desires were involved (Johnston & Patel, 1987; Stephenson, 1987b). Pharmacies were selected as outlets partly because they offered commercial expertise in dispensing syringes within a monitored health framework. This seemed very useful in enrolling public, political, and professional support. The peer-professionalism I describe would have been resisted more strongly if the initial NEP had been overtly peer influenced, rather than such aspects becoming public and extending in stages (Robinson, 1990: 26). The pharmacy NEP model solidified some connections across the conflicting boundaries of crime and health by entangling them in normal, everyday work. Pharmacy work also emphasised the overtness of the commercial arrangements rather than the exceptional forms of organising that featured unusual education programmes, special events, and discreet outreach. Normal commercial activities reinforced the need for peer participation while reassuring the stakeholders that IDU clients would not be deterred by media attention. The commercial pharmacy aspects of the NEP helped the new peer-professionals to counter the exceptionalism and stigma⁴⁴⁰ that attached to purely IDU-connected aspects of peer outreach groups (part. obs. 1989-1991).

The NEP environment was hazardous due to the fragmentation and unpredictability of the health sector 'destructuring',⁴⁴¹ and to the associated budget constraints. Furthermore, being an exception to the prohibition of drug paraphernalia and the criminalising of self-medication created a hazardous isolation. Hazards notwithstanding, commercial expertise was 'normal' in being approved and pervasive in a neo-liberal era. Previous peer organisations such as the IV League, and previous peer occupations such as political lobbyist, had been unstable in the sense of lacking the normality of such organisational and occupational support. Pharmacy exchanges stabilised the NEP

440. The extent of this stigma is indicated by NEP pharmacists in Christchurch being considered "the lowest of the low" (CIVDURG, 1988a) by their colleagues. The District Advisory Pharmacist commented that the number of outraged pharmacists was small but vociferous (CIVDURG, 1988b).

441. My use of the term 'destructuring' refers to the fragmentation of a previously more integrated and centralised hierarchal system of bureaucracy. It also refers to the resultant difficulties in communication and predictability having been intended to disrupt previous structures and encourage more vulnerable structural innovations. The term 'restructuring' is often applied to the neo-liberal state sector changes after 1984, but the term destructuring seems more apt. This is shown in the difficulties experienced by the peer groups which, in being isolated at a low level of service delivery, were caused by a logic of permitted, or deliberate, central oversight. The reformulated health sector was denied previous structural arrangements and left with only market methods and logics. Yet the goals of the health system remained inherently caring and careful rather than commodified and entrepreneurial. Because there was less structure to achieve health goals, destructuring has been used as a more precise term than restructuring.

by treating syringes as a highly regulated, but otherwise normal commodity, to be transported, counted, and made accountable in conventional commercial ways.

The NEP planners realised that a working structure that necessitated firm contracts and required repeated evaluation needed to be accepted by stakeholders ahead of the legislative deadlines. Such planning was difficult because the enrolled stakeholders could not be supported in a mutual alignment by a well-established body of theory or practice, as occurs in the dominant professions. The NEP methods were more pragmatic than theoretical, and the *Ottawa Charter* was a theory of ideals and high level strategy, rather than procedures that enrolled all the NEP stakeholders in clearly defined roles. Instead, the pharmacists, advisory committees, medical associations, and police were all well-resourced in their independent motivations, their different theories, and their intersecting rather than shared practices. Consequently, changes to the NEP involved formal and genuine consulting with stakeholders who could not be safely ignored (Fitzgerald, 1995: 3, 6, 14).

An important exception lies in the area of peer group organisation. For instance, in 1990 the National Council on AIDS policy recommendations (1990a: 80-81) were for local peer groups to be left alone to manage their own arrangements, provided that national protocols and goals were being pursued and the expenditure was accountable.⁴⁴² The peer groups were contracted to provide services, not to follow any particular internal structural model, nor to fit into any external governance environment. Political and bureaucratic institutions were not established at a national level. Accordingly, a space opened for mid-level, 'implementational' national developments that were promoted through improving the commercial infrastructure and market efficiencies. These disciplined efficiencies required that the logistics of transporting and exchanging syringes, along with the accompanying activity of IDU motivation change and representation, produced professionally accountable records. Successful commercialisation seemed a valuable asset to the NEP outreach goal, given the vulnerability of IDU to accusations of irrationality, non-compliance, and lack of control (Nimmo, 1995a, 1995b, 1995c).

From 1990, the policy, advisory, and service delivery aspects of the Department of Health were financially restricted, and in 1993 these became fragmented into an array of more isolated, competitive, risk-minimising, and vulnerable agencies (Thomson & Wilson, 2001: 241, 242). The NEP was considered too unimportant to require direct political direction from Cabinet, yet after the AIDS Task Force was disestablished by August 1991 (Penrose, 1991), no single state agency was accountable for the national co-ordination of HIV/AIDS prevention and policy, including the NEP with its inbuilt antagonisms.⁴⁴³

442. This policy was formulated when Rodger Wright was the IDU representative on the National Council.

443. The National Council on AIDS never received full government support for its National Strategy, and was itself disestablished only several years later. It, or an equivalent, has since been reconstituted, but similar issues of ambiguity of role and uncertain government support have become apparent in 2007. Since it does not seem to meet, or address crucial issues in other ways, apart from nominally existing, the newer Council seems decorative at best.

In 1988, the IV League⁴⁴⁴ had recognised that its 'charismatic' type of entrepreneurial⁴⁴⁵ health promotion and organisational model was suited for political lobbying, yet unsuited for providing a national outreach programme that linked cohesively with the pharmacy-based NEP. IV League spokespersons suggested a compromise consisting of a tightly structured, service delivery-orientated organisation of peer educators, employed and supervised by the Department of Health.⁴⁴⁶ This organisation and system would have its personnel and other peer resources supplied by the IV League. However, the AIDS TaskForce official administrators did not accept that the IV League could represent the differences among IDU, nor the collective needs of IDU, in this way.⁴⁴⁷ These officials desired a wider range and larger numbers of IDU representation, yet did not wish to be directly accountable for supervising such representatives.

Robert Kemp had initially promoted ADIO as being locally representative and having a low public profile, in contrast to the national IV League. By later persuading the Department of Health to add a commercial syringe outlet to ADIO's peer outreach activities, Kemp produced a hybrid organisation and duplex system of accountabilities in stages (Kemp, 1988a, 1988b, 1988c). The double accountabilities and resultant uncertainties were offset against the opportunities inherent in making two types of opposed activities mutually supporting. However, Kemp wanted a further stage that involved developing ADIO, and any peer groups following its model, into regional service and administration blocs. Kemp argued for a national structure of five regional blocs for peer activities, rather than urban centres with the same number of outreach employees but less coverage and fewer resource commitments (Kemp, 1988a).⁴⁴⁸

The supply of syringes at ADIO centred around a single operational site where expenditures could be largely met by user-pays income. The extra funding for education and outreach could be readily controlled by state agencies through service contracts. The loss of regional coverage, the consequent disincentives to outlying IDU prospective clients, and the loss of total coverage, were accepted by government politicians and official agencies. Any alternative arrangements of regional blocs would have increased costs and reduced the benefits of a user-pays model. The Department's need to minimise its financial and administrative accountabilities perhaps explains why Kemp's regional bloc model was rejected. Outreach needs were unevenly distributed across a regional bloc,

444. The IV League consisted of two spokespersons who lobbied at a national level and travelled around the main cities encouraging IDU to form groups. By 1988, several groups had formed in a loose federation. However, there was no regular service delivery component, only intermittent AIDS TaskForce contracts to carry out surveys. The spokespersons could speak as HIV positive, gay men who were also IDU. This gave them credibility and official access as individuals, but not funding for the organisation they founded.

445. Entrepreneurial here refers to being innovative and catalysing change, not to being profit-focused.

446. In 1990, this concept was revisited as an option in Robinson's recommendations on peer group development (1990).

447. As also found in Robert Kemp's initial proposals for ADIO.

448. If these were administered at mid-level, since the previous pattern of Department of Health hierarchy could not be guaranteed, they would also be administrative blocs. Since local differences would be averaged within the blocs and reduced in number between the blocs, a single standardised pattern of organisation was indicated. Kemp seemed to be preparing the way for an administrative hierarchy that could be employed to direct local peer group affairs from a central national position.

since IDU actually injected drugs for private reasons, not to fit into public administration models. The rejection of regional blocs effectively ensured that outreach remained dependent on user-pays, with many gaps, such as rural areas, prisons, and youth. In 1987, outreach was not expected to be user funded, yet by 1994, a Ministry of Health analyst assumed it would be, which indicated some changes in the policy environment (Walzl, 1994: 52).

ADIO worked by requiring those already identifying as IDU to be personally motivated to visit its urban-centralised outlet. At the time, outreach was an ambiguous concept with a diversity of interpretations. The IV League proposals presented outreach as complementary to, but different from professional counselling (Wright 1987, 1988a). Counselling was to be provided at different types of centres, such as drug treatment clinics, but outreach was to be peer-to-peer, close to everyday injecting activities. The ADIO model effectively combined these different activities by requiring IDU to visit a needle exchange for syringes as a regular activity that exposed IDU to peer-professional environments of combined counselling-outreach. The ADIO model competed with any counselling services being provided to pharmacies by some other agency. The supply of syringes and the accompanying peer outreach had become channelled into a shop-clinic model. IDU, as clients, customers, peers or patients, circulated to and from a centre of controlled access to health products. This system was cost effective and workable, yet inherently linked the health-oriented outreach to the commercial aspects of user-pays and the logistics of moving syringes. By being founded as an experiment in outreach, and in being successful, ADIO effectively consolidated its organisational and market concept in a commercially stabilised way that was urban-centred, regionally-absent, yet dependent on the national co-ordination provided by state funding agencies and regulations. These developments have been discussed in more detail in Chapters 5 and 6.

In 1990, Kemp was employed by the AIDS TaskForce to explore the service provision potential of the recently created Area Health Boards (Kemp, 1990).⁴⁴⁹ Kemp proposed that the TaskForce would fund the Area Health Boards to provide epidemiological testing programmes for returned syringes, and employ at least one outreach/advisor per region.⁴⁵⁰ Kemp argued that the TaskForce needed to monitor HIV prevalence among IDU more intensively in both non-urban and urban areas. This would help prevent a critical mass of HIV-positive IDU emerging, by providing data for prioritising and legitimising needs-based expenditure. Kemp's proposed system for monitoring relied on frequent, large-scale HIV seroprevalence testing of returned syringes (1990).⁴⁵¹ However, the TaskForce had no secure funding for the national coverage of non-urban regions. Even if

449. There were fourteen Area Health Boards, of which five included peer groups in their regions.

450. Kemp appears to have changed his stance since 1988, when he critiqued the IV League proposal for employing three full time and 12 half-time outreach workers as "excessive human and economic resources" (Kemp, 1988a).

451. Kemp acknowledged the significant dangers of IDU distrust in testing returned syringes, since: "it would raise fears amongst consumers" (Kemp 1990: 7).

funding had been secured, the Area Health Boards refused to provide services under the TaskForce's direction, which forced the TaskForce: "to respect the autonomy of AHB's [sic] in deciding best how to allocate services in their region" (Kemp, 1990).⁴⁵² In effect, Kemp attempted to sell these services to the Area Health Boards, since they could arrange for professional expertise in co-ordinating regional administration, and because they had seemingly more secure funding than the TaskForce. Kemp did not attempt to build such a testing and outreach programme through the existing TaskForce-funded peer groups, even though these had already co-operated with existing centres in epidemiological testing, as discussed in Chapter 8.

Kemp's concerns have seemed well-justified by the potential rapidity of HIV transmission amongst social and market networks of secretive IDU. However, his plans required linking peer-professional activities to an already existing infrastructure of regional health administration.⁴⁵³ The logics involved seem similar to those of universal primary health coverage, but instead focused on a marginalised and geographically unfixed community. The administration of such plans did not rely on the existing pharmacy network and so could not readily share their management costs. Accordingly, the proposed system could not be self-funding through user-pays, yet the Department officials and politicians did not consider that it required state funding (Aitken 2002: 45). Kemp's attempts at constructing a nationally co-ordinated health infrastructure based on Area Health Board support for peer group outreach was not sustainable in the neo-liberal health sector environment of the time.

Kemp's approach of trying to build up elements of a fragmenting health sector involved trying to align many opposing or self-interested elements in stable arrangements. This may be another reason, apart from the high management costs of the peer groups,⁴⁵⁴ why Kemp advised against increasing the numbers of exchange outlets (1990). This advice contradicted the National Council on AIDS recommendations to increase peer group numbers. Kemp's advice also indicated a shift in AIDS TaskForce strategies from its initial goals of increasing the number of groups.⁴⁵⁵ However,

452. A locally controlled Area Health Board might not prioritise preventative work designed to empower marginalised communities.

453. When Rodger Wright resigned in 1990, due to increasing illness, Robert Kemp was appointed IDU representative. Although having proposed the isolated urban peer group model, Kemp had also recommended larger geographical administrative blocs (Kemp, 1988a). This model seemed to entail larger administrative loads and greater strains on the abilities of IDU to work to professional standards, or to require increasing numbers of non-IDU or ex-IDU to work as administrators. Kemp seems to have envisaged such models in terms of "a wider perspective" (National Council on AIDS, 1990b: 1). Kemp's attempts as NEP co-ordinator to re-organise the peer groups from urban centres into blocs would have entailed peer group reformulation into a bureaucracy. This would have created difficulties during a period (1990 to 1995) when increases in group numbers and funding were successfully resisted by state funding agencies. It would also have disrupted the protocol of non-interference in the internal organisation of peer groups, while reducing the responsiveness of groups to local conditions by widening and diluting their focus. Kemp's attempts at co-ordinated coverage were rejected by the peer groups (Nimmo, 1994a). Distrust of centralised authority, and consequent awareness of interplay between bureaucratising and co-ordinating of peer-professional influence on the NEP, later contributed to the federal rather than bureaucratic shape of NENZ.

454. High compared with the private sector. See Robinson (1990: 16, 18-19).

455. The AIDS TaskForce co-ordinator of the NEP initiated discussion with several peer group proponents during 1989, and planned a West Coast fact-finding survey aimed at starting a peer group.

no more funding proved available for plans for wider coverage by a more effective or efficient administration, than was available for increased numbers of peer groups.

Kemp made little headway with the Area Health Boards before his initial support base as a contracted AIDS TaskForce employee disappeared upon the disestablishment of that body. Although Kemp successfully shifted to becoming employed by the NZAF and New Zealand Drug Foundation as 'National Advisor IDU/AIDS', the NEP stakeholders had been careful to ensure that such positions: "were consultative not executive" (CASONZ, 1991c).⁴⁵⁶ In 1992, Kemp released a policy paper on IDU community development. This paper proposed that the peer exchanges should not increase in numbers, but should instead consolidate into regional blocs. The recommended number of blocs had reduced from five to three since 1988 (Kemp, 1992a, 1992b).⁴⁵⁷ Two North Island blocs and one South Island bloc were proposed. The suggested benefits included reducing management costs while increasing coverage and consistency in service provision. However, Kemp could only propose, not dispose (Kemp, 1992b). Groups such as CIVDURG (1993) and DIVO (1993a) opposed the altering of sustainable local arrangements which at that time were addressing a network of personal, organisational, IDU, and AIDS Service Organisation needs. Such regional resistance helped to prevent any administrative restructuring that seemed to jeopardise the existing IDU community developments.

State agencies could not easily assist in such administration building projects, since an existing protocol emphasised that: "it would be inappropriate for the Department to intervene in a matter which is internal to [a peer group]" (Van der Lem, 1991). The boundaries between internal group arrangements and external arrangements were fairly ambiguous. State agencies in a neo-liberal environment would not have been interested in being directly accountable for matters that touched on private group arrangements.⁴⁵⁸ This protocol of non-intervention added to the recommendations from the National Council on AIDS (1990a: 80-81) to let the regional peer groups develop their own methods of health promotion. The protocol and recommendation opened a space for commercial opportunities that were pursued through management logics of effectiveness and efficiencies. For instance, ADIO began in 1993⁴⁵⁹ to openly sell non-regulation syringes suitable for steroid users. ADIO also supplied the NEP pharmacies in Auckland with bulk-ordered injecting

456. The DIVO co-ordinator considered the appointment had been rushed and manipulated (CASONZ, 1991a; Lee, 1991).

457. Contrary to the National Strategy of the National Council on AIDS (1990a: 108), of which Kemp was the IDU representative, and contrary to Kemp's job description from CASONZ to work with users to set up new groups (Lindberg, 1991a, 1991b). It seems apparent that, given the tensions of this co-ordinating role and the need to maintain trust, the reinterpretation of these accountabilities would not have occurred without compelling reasons.

458. The only direct intervention had been by Helen Clark, the Minister of Health, in 1990. Clark had instructed that co-ordinators of IDU groups and IDU employees not be Trustees. This prevented employees controlling the conditions of their employment, and reduced problems of employees being effectively unaccountable. See Robinson (1990: 20).

459. Before this illicit syringe supply became normal, earlier problems with police needed to be resolved. The police had objected because on arrest, IDU had stated that they had bought illicit 1 ml syringes from ADIO (CIVDURG, 1990c).

supplies.⁴⁶⁰ By 1995, ADIO supplied twenty different combinations of illicit needles and syringes with the informal knowledge of Ministry of Health officials.⁴⁶¹ Such demand-side, market models of consumer choice and commercial efficiencies shaped the consequent administrative developments in several ways. Since the government funding and NGO grants reduced as HIV/AIDS seemed less of a public threat, the need for commercial expertise was increasingly emphasised. The peer co-ordinators could resist pressures to reduce their wages, because income increased as the number of sales increased and costs decreased due to commercial efficiencies. The outreach became subsumed into the peer 'shop' exchange, rather than being attempted in stand-alone ways that required dedicated funding to be first separated from the syringe logistics, then justified in an activity that had been notoriously difficult to monitor. The professional and official types of health administration that depended on external funding through hierarchal structures or contract negotiation cycles, or private grants from charitable agencies, became complemented, though at times conflicting, with management methods that focused on the efficiencies and motivations of open market interactions.

2 NENZ: An emergent, centralised professional body

In August 1989, a body called the Community AIDS Services Organisations of New Zealand (CASONZ) was formed by the NZAF (National Council on AIDS, 1989d; CASONZ, 1990a) in response to recommendations from the World Health Organisation⁴⁶². CASONZ included all the AIDS service organisations that worked in the area of HIV prevention and AIDS support and were funded by the AIDS TaskForce. CASONZ did not carry out service work. Its quarterly meetings depended on AIDS TaskForce funding.

CASONZ provided a forum for sharing information and developing research, policies, strategies and initiatives. It co-ordinated advocacy while also providing advice for the AIDS TaskForce. CASONZ represented marginalised communities, pressured the TaskForce to lobby for increased AIDS funding, and criticised some details of previous expenditure.⁴⁶³ As the government expenditure on AIDS lessened, so did the TaskForce budget on which CASONZ depended to function (CASONZ, 1991b). The archived CASONZ records stop in April 1992.⁴⁶⁴ By then the AIDS TaskForce funding and staffing levels had ceased to function adequately for providing

460. These products included sterile water, filters, and antiseptic skin products, and tourniquets.

461. See DIVO (1994a), Nimmo (2004 pers. com.), Beswick (1995a).

462. The WHO promoted an international model called the International AIDS Service Organisation group.

463. For instance, on a womens' health pamphlet that the AIDS Service Organisations said was misinformative and wasted funds (CASONZ, 1990c). CASONZ attempted to provide a forum for sharing information; co-operating on research, policy, strategies and initiatives; co-operating on advocacy on policy issues, legislation, and funding; and acting as an advisory group to the AIDS TaskForce. In 1989, the AIDS TaskForce was very supportive of CASONZ, but the AIDS TaskForce membership and goals changed rapidly during the following years.

464. During this period, peer groups were informed by the AIDS TaskForce that they should approach their local Area Health Boards for support, since their core funding was not guaranteed to be secure (CASONZ, 1991b).

information and maintaining connections to other state agencies. The AIDS TaskForce was itself disestablished by 1993, further isolating the NEP peer groups.

The absence of regional administrative blocs meant that the peer groups remained isolated, since no ‘middle layer’ of communication and connections could take over from the TaskForce’s higher level co-ordination of administration and funding prioritisation.⁴⁶⁵ The peer-professional groups wanted to deregulate the NEP, since the costs of importing, packaging, and transport were tied to the regulatory environment of Department price setting, as described in Chapter 5. A more professional image, and a more central coherent position from which to lobby for funds and deregulation, seemed needed. The peer groups’ shared concern for: “the importance of a national spokesperson on IDU issues” (DIVO, 1993b), led to calls to form a national organisation.

Nonetheless, this concept of national, central co-ordination did not become sufficiently problematised, nor enrol sufficient well-positioned support until promoted by the Public Health Commission.⁴⁶⁶ This Commission had been founded in 1992, then empowered a year later under the *Health and Disability Services Act 1993*. This Act separated the previous Department of Health into a policy-only Ministry and a Public Health Commission. The Commission was accountable for directly funding any national aspects of implementation of the population-based, public health policy.⁴⁶⁷ The Commission was more independently positioned, and more distant from political influence than the Ministry of Health (Thomson & Wilson, 2001: 241). The Commission contracted services from provider groups and was closer to the sites of implementation of service delivery. The Commission competed with the Ministry in terms of policy control, while confronting various agencies, such as the Alcohol Advisory Council (ALAC)⁴⁶⁸ and Customs, whose income and rationale for existing relied on the alcohol industry. These agencies contributed significantly to the disestablishment of the Public Health Commission in 1995 (Hutt & Howden-Chapman, 2001: 261, 266).

465. Several employment problems had been limited in the extent of their damage to relatively isolated and discreet peer groups. The same problems, if erupting across more numerous connections in a more public environment would have been extremely damaging to the NEP’s public and political acceptability.

466. The Public Health Commission’s involvement in commercial aspects of substance control policy is analysed in Thomson & Wilson (2001) for tobacco, and Hutt & Howden-Chapman (2001) for alcohol. In my reading, the Hutt & Howden-Chapman account is sceptical towards arguments that pleasure is a social good. It does not clearly distinguish pleasure from dependencies, or from desired commodities. It critiques the way “poor definitional and analytical rigour” associated with post-modernism had aided industrial lobbying. It neglects the way that everyday experiences of pleasure from alcohol use made a mockery of well-intentioned but authoritarian medicalising arguments which had excluded public goods of pleasure from analytical and policy considerations.

467. The Public Health Commission seems to have relied on rigorous evidence-based reports, somewhat in contrast to Treasury and the Ministry of Health at times (Hutt & Howden-Chapman, 2001). The Commission was concerned with harms caused less by intense substance use, but by moderate long-term use of licit substances, such as tobacco and alcohol. Its evidence-based analysis of harms led it to a generalised and aggregated analysis of whole populations, rather than a stigmatised minority who used illicit drugs. Accordingly, instead of allying with police and law enforcement against relatively vulnerable people, such as IDU, it challenged extremely well-resourced corporatised industries with many political and Departmental beneficiaries. Such a stance did not endear it to those who wished to manage rather than minimise the harms associated with the profits, and taxes, of such industries. A population health perspective was highly political.

The Public Health Commission had become responsible for contracting the peer groups on behalf of the Ministry of Health (Ministry of Health, 1995a: 4). The peer groups generally agreed on the: “importance of developing and maintaining a good relationship with the Public Health Commission ... and sharing of resources” (Clayton, 1993). However, peer groups such as CIVDURG and DIVO had come to oppose losing their close connections with their regional funding agency, which seemed better informed on local needs after initial difficulties. To these groups, being funded by the Southern Regional Health Authority seemed no less secure than by the Commission.⁴⁶⁹

NENZ had been conceived of in terms of national scale public health goals and methods, but as specified by officials of the Public Health Commission rather than of the Ministry of Health. The initial models called for NENZ to bulk fund the peer groups and to distribute information. It was clear from the peer discussions that bulk funding involved a degree of hierarchal control that would shape any representation over the policy goals, methods, and evaluation of the NEP (1995 part. obs.). The groups did not agree on formally establishing NENZ until the proposals for bulk-funding were dropped in late 1994. This minimised the criticisms that were based on distrust of empire-building and threats to autonomy, and allowed the interests of the peer groups and the Commission to become better aligned. The foundations on which the peer groups all agreed to federate included the co-ordination of services and information, the provision of representation in future negotiations with the Public Health Commission and Ministry of Health, and implementation of specifically national types of activities (Auerbach, 1994a, 1994b, 1994c; Luke, 1994).

By November 1994, the Public Health Commission officials had become frustrated by two years of lack of progress towards national co-ordination, and consequently refused to fund any further meetings. Instead, they urgently encouraged the incorporation and initial funding of NENZ by offering a one year, \$25,000 contract to improve the co-ordination of the peer groups. This was effectively a payment for NENZ to become a legal entity. The officials finally acted with such rapidity and inducements because the government had announced the Commission's immanent disestablishment.

The Commission officials had been both freed⁴⁷⁰ and challenged to use their available resources towards more directly fulfilling their mandate to protect public health in evidence-based, nationwide ways. The Commission consolidated a financial commitment for public health promotion activities by creating and contracting a legal, national organisation with a public health-oriented constitution. The aims of this Constitution included HCV prevention, and the objectives were

468. The Alcohol Advisory Council of New Zealand (ALAC) was established in 1976 to encourage responsible use and minimise misuse of alcohol. ALAC is funded by a levy on alcohol sold in New Zealand. The levy has been collected by Customs, and other agencies.

469. See DIVO (1993a, 1994b, 1994d,), CIVDURG (1993). Neither SRHA nor Public Health Commission could offer multi-year contracts around which stable professional planning could be based.

470. The officials could then afford to take political and career risks, because their agency would not exist later to transfer accountability for consequences to themselves as individuals.

designed to facilitate professional capabilities, such as internal evaluation, library resources, training and education resources, and gaps in the coverage of harm reduction services (Harris, 1994: 4-5). Other objectives specified defending the human rights and civil liberties of IDU, while promoting the interests of Member Groups and their clients in relation to regulatory and statutory bodies. A further objective promoted the national purchasing of NEP supplies. In so doing, the Public Health Commission prevented the Ministry of Health from halting or undermining the formative shaping of NENZ.⁴⁷¹

When the Public Health Commission was disestablished in July 1995, its contracting accountabilities were transferred to a single national funding body. This was a nominated RHA⁴⁷² rather than the Ministry of Health. Whether and how this RHA, or NENZ, should act for the Ministry in an implementation and co-ordination role was negotiated around mid-1995.⁴⁷³ The negotiators accepted that there was:

little effective evaluation of the scheme; return levels of used needles/syringes are largely unknown and where they are known, they are shown to be low; IDU outreach groups have become increasingly frustrated by a scheme which they see as not working ... [the] fragmented administrative and contracting systems in existence; the continued sharing of used needles ... [the] use of injecting steroids is increasing ... [The] declining interest in the scheme among pharmacists ... further threatens coverage. (Ministry of Health, 1995a: 3-4)

The Ministry of Health accepted that its own educational material was seen by IDU as: “propaganda” (Ministry of Health, 1995a: 8), and that continuing high rates of HCV might result in high treatment costs. The Ministry officials also expressed disquiet over the significant cost increases to what they had imagined was a pure user-pays scheme (Ministry of Health, 1995a). Such fears seem to have been countered by separate fears of the political risks of adverse publicity (Walzl, 1994), along with a reluctant, tacit admission that HCV prevalence required additional motivation change among a non-compliant population of IDU. Given such considerations, the commercial viability of the NENZ proposal made more sense than the Regional Health Authority or Ministry alternatives, despite forgoing the efficiencies and controls offered by bulk funding. No alternative to NENZ could offer the advantages of dedication and experience identified by Walzl (1994) in his analysis of the national transport and packaging logistics.⁴⁷⁴ Furthermore, NENZ had taken up the initiatives developed by ADIO to actively:

471. This was quite intentional, as expressed informally to peer representatives, including myself, at the time.

472. This RHA was North Health, further from the South Island than the seat of Government and state agencies in Wellington.

473. This negotiation was premised on the Ministry of Health commissioned Walzl report (1994), on an internal Ministry of Health review of management issues (Fitzgerald, 1995), and on a review by Kelly Auerbach (1994d) commissioned by the Public Health Commission. Auerbach was the peer group negotiation co-ordinator previously employed by the Drug Policy Forum on behalf of the Commission. It seems that this roundabout system of funding, also seen in Robert Kemp’s employment, allowed research and co-ordination to occur that was impossible under the constrained HIV/AIDS and HCV budgets. Instead, drug education funds were employed for this purpose, illustrating a way in which harm reduction policy made inroads into previous abstinence promoting funding streams.

474. The RHAs were too regional and disconnected to provide co-ordinated national planning. The nationally accountable Ministry of Health resisted providing actual coverage because it avoided implementation role where possible.

recruit new pharmacists and to try to create a support service for them in order to increase their retention in the programme. Secondly we were trying to break down the “pack” service model (and break the Salmond Smith Biolab monopoly) and encourage pharmacies to sell single fits, filters, and sterile water”.
(Nimmo, 2006. pers. com.)

The reluctant acceptance and support of NENZ by the Ministry of Health shows the significance of the peer groups having attained commercial competencies that were self-promoting and public, though illicit. The illicitness has seemed to express a deviant social value, and been tacitly recognised as such, by the same officials who then attempted to regularise, normalise and make formally good what was already actively good by being formally bad. Not only had syringe prices been minimised through the commercial arrangements and logics, but other goals had also become possible. The commercial expertise helped to stabilise the unfunded peer-professional attempts at improving syringe supplies, at providing other IDU services, at empowering IDU through employment, at trialling methods of motivation change of IDU, and at representing IDU to health and police agencies. These harm reduction projects were then linked by peer-professionals and officials to a nation-wide infrastructure that was professionally run and accountable in the form of NENZ. Such scope and stability increased the prospects for peer-professional bodies to supply expertise for on-going research and governance projects.

NENZ was created through an alliance with officialdom, albeit a shifting set of officials. Notwithstanding, NENZ followed a Public Health Commission reflex tendency to attempt policy inputs that generated resistance from other, more politicised agencies. These attempts were both problematised and productively leveraged by NENZ’s closer involvement than the Ministry in mid-level implementation of health policy. In 1995 the Ministry became NENZ’s funder ‘partner’ but also a negotiating opponent.⁴⁷⁵ Ministry officials inherited the Commission’s contract for NENZ, imagining: “that the NENZ proposal would largely operate as a user pays supply scheme” (Ministry of Health, 1995a: 3).⁴⁷⁶ Instead, these officials found themselves negotiating over a one-off, \$80,000 establishment grant and an annual operating budget of \$120,000, for what they understood to be an outreach co-ordinating body. NENZ eventually satisfied the Ministry that it could efficiently improve the NEP services at little extra cost, and without directly increasing the funding or the Ministry’s accountability to the urban peer groups.⁴⁷⁷ NENZ, accordingly, came to employ the NEP co-ordinator and was contracted by the Ministry to provide this service.⁴⁷⁸

475. The peer groups were separately funded through the Northern RHA.

476. Whether this impression had been deliberately, or carelessly, created by the Commission, or due to wishful thinking by the Ministry, is unclear.

477. Regional level negotiation, especially over extra funding that had not been budgeted for at a national governance level, would have set an irritating precedent for the Ministry governance model.

478. NENZ was not the only co-ordinating body. In 1995, the Ministry of Health also created a NEP stakeholder’s committee that included the Ministry, RHA, Pharmacy Guild, Pharmaceutical Society, and peer groups. However, this committee was advisory only. It did not directly implement policy, nor co-ordinate delivery of services. Because it could not control crucial mechanisms, and has not caused any key events, it is not discussed in any further detail. Refer McNicholas et al. (1996, cited in Kemp (2004). However, the Stakeholder Committee has been active in a network sense of facilitating and shaping aspects of communication.

By April 1995 the need to lower the prices of the syringes along with the costs of their distribution and disposal led to further proposals. These were for the packing and transport work to be incorporated into the NEP infrastructure rather than being commercially contracted out. Such work was offered to NENZ in the form of a commercial contract, intended to advance the non-profit health goals of the NEP. Simon Nimmo, the key NENZ negotiator,⁴⁷⁹ informed the peer groups: “we are required to develop a tendering document offering our services to the Ministry ... with a view to us taking over supply and distribution of all packs from the 1st of October 1995” (Ministry of Health, 1995b: n p).

The Ministry of Health’s neo-liberal environment and pragmatic principles of organising health services fitted well with proposals for local communities to be serviced by regionally contracted local community groups. Yet such principles also promoted the representation of consumers and the management of health services at mid-level by private agencies. NENZ could justifiably be funded for its consumer representation at a Ministry policy level, and as a provider of mid-level co-ordination of service implementation, yet also work between these levels as a provider of experimental pilot programmes that engaged directly with IDU.⁴⁸⁰

These developments of national co-ordination were somewhat akin to Kemp’s earlier proposals, were related in their logics to the even earlier IV League proposals, and still bore the 1985 gay activist imprint of community empowerment. Moreover, because these sequences of development were combined with constant, institutionalised shapes of opportunity and distrust, the regular circulations of syringes and money helped to consolidate events in new unpredictable forms and understandings. The trajectory of NENZ was very much like a personal career in being both structured and random (Abbott, 2001: 161-164). Nimmo emphasised such peer-professional aspects when he noted that moving into this new occupational territory and status entailed greater accountabilities, since:

The provision of packaging and distribution of all needles and syringes is a key control area in terms of the programme. By taking control of this area and the production of educational materials used in the scheme, the members of Needle Exchange New Zealand are effectively taking control of the programme (under contract to the Ministry of Health) with the exception of the regulatory aspects. While this is desirable in terms of health goals it carries [sic] a substantial responsibility with it. (Nimmo, 1995b)

Nimmo linked his emphasis on health goals to a Ministry of Health requirement that the financial proceeds were to promote education, not regional salaries, nor unaccountable overheads. He described the profitability as negligible and the administration overheads as considerable, yet nonetheless desirable for improving relations with local pharmacies. The latter point is significant. After the NEP was founded in 1988, the number of participating pharmacies had dropped

479. Nimmo had succeeded Kemp as ADIO co-ordinator, then became the NENZ co-ordinator after Auerbach in 1995.

480. See Nimmo (1994a, 1994b), Walzl (1994), Fitzgerald (1995), CIVDURG (1995).

significantly in the early 1990s (Nimmo, 2004. pers. com.). In response, ADIO had instituted a policy of recruiting and supporting pharmacies. ADIO had also bypassed the original sole supplier of syringes⁴⁸¹ and bought a range of injection equipment directly, and illicitly, from pharmacy wholesalers.

By June 1996, IDU groups transacted 56% of the NEP injecting equipment ordered from wholesalers (Kemp, 2004), largely through the co-ordination provided by NENZ. NENZ gained greater control over the lowering of costs than had pharmacies, yet could not easily control the range and bookkeeping arrangements of the discounts offered by its member groups. The NEP stakeholders approved of passing on the profits from any economies of scale into the better provision of education materials. However, the NEP pharmacists objected if the regulated price was reduced or undercut by the peer groups, since such competition impacted on their profitability. The more the peer groups took control of their commercial operations, the more their scope and scale of purchasing and selling increased. Yet this increase risked a conflict with the profitability of the same pharmacies that guaranteed national coverage. Peer groups could not provide such coverage. The trial that emerged was a trial of professionalism. The peer groups were challenged by the situation that they increasingly controlled to use that control to work with, rather than against, the NEP pharmacies. By forming NENZ, and prioritising relationships with pharmacies, the peer groups developed a method of increasing their professionalism along several fronts that reinforced each other.

After a hesitant start, Ministry of Health officials encouraged NENZ to develop in this professional way that mixed the health logics for supporting pharmacies in collegial systems, with the commercial systems of logistics that risked undercutting pharmacies (Nimmo, 2004. pers. com.; Ministry of Health, 1995a). However, since NENZ was a facilitating rather than a regulation enforcing organisation, it was the autonomous member groups that provided the primary influences on its direction. They voted to professionalise rather than bureaucratised, which enhanced rather than diminished their autonomy as peer-professional groups and as a peer-professional occupation.⁴⁸² After the mid-1990s the peer-operated exchanges began to increase in number, yet also in scope and professionalism, with the assistance of NENZ. NENZ has seemed a professional instrument for facilitating new peer groups, reorganising costly areas of the NEP infrastructure, passing savings back into the equipment supply and motivation change components of the programme, and supporting high level negotiations over policy direction.

481. This was Salmond Smith Biolab formed in 1986 from the merger of Salmond Industries and Smith-Biolab merged to form Salmond Smith Biolab Ltd with Biolab Scientific Ltd named as the scientific supply division within the Group.

482. I acted as a CIVDURG representative at this meeting. Although CIVDURG was in dissolution, I reversed the previous objections of CIVDURG representatives to joining NENZ, and conveyed the views of the Christchurch exchange workers, which firmly supported NENZ. One of the first acts of the DISC Trust was to join NENZ. All those attending the formative NENZ meeting wanted more professional, peer delivered services for IDU, and none advocated for a NEP bureaucracy. Officials were regarded with wariness, even when supportive.

The then existing types of NEP service contracts remained with Regional Health Authorities,⁴⁸³ while those agencies existed, because responsiveness to local IDU environments remained a significant goal. NENZ was useful in a different way by being directly and rapidly talked to, as a single voice that was more directly accountable to the Ministry of Health through its funding contract than any regional group could be. Accordingly, NENZ did not become disestablished as had previous national co-ordinating bodies such as the Public Health Commission, the National Council on AIDS the various AIDS TaskForces, and CASONZ. NENZ was more sustainable in how it could utilise commercial logics to align its accountabilities to the Ministry and to its member groups. NENZ's distance from IDU life-worlds, while drawing on the experience of dedicated peer personnel, was undoubtedly a strategically significant factor in avoiding problems such as those that CIVDURG experienced. However, personal dedication and a clean record would not by themselves have been sufficient to drive the tough bargaining that represented IDU against an extremely powerful state agency. The relative stability and bargaining capabilities of NENZ seem best explained by its development of commercial logics, practices, and expertise while retaining the shelter of a specialised, health professional niche, and the shelter of illicit IDU associations.

The education and harm-reducing, outreach aspects of the NEP could never be income earning, yet were attached to the logistics of circulating injecting equipment through the commercial logics of accountancy. NENZ was not only an entity that could be named as if a single solid actor, but was also an effect that emerged between a network of stakeholders who used a range of organising logics. This effect partially compartmentalised such contradictions in a specialisation of expertise. This made the problems of internal hybrid conflict more manageable, while also encouraging the IDU involved in providing the NEP services to act more effectively by drawing on a range of peer-professional identities. NENZ accommodated hybrid conflicts, and lifted them to a more professional level of abstraction and accountability in long-term planning. However, NENZ also engaged in direct service work and research that benefited the peer groups, while providing co-ordination services.

In actor-network terms of 'translation' (Callon, 1991, 1999), NENZ first 'problematised' by defining a problem in terms of NENZ being a solution. This led to regular interactions in the form of yearly meetings funded on a one-off basis. Then the interests of the individual stakeholder groups were problematised and satisfied by being included as essential in the development of a more solid relational proposal. When the interests were committed, the connections and divisions of activities

483. The history of changes from district branches of the Department of Health to Area Health Boards to Regional Health Authorities to the Public Health Commission, to the Health Funding Authority, to the Ministry of Health, and to District Health Boards over a twelve year period cannot be discussed here. Suffice it to point out that health funding directed at a stigmatised community has to be ring-fenced or centralised to prevent local majority communities diverting such funds into majority health concerns at the expense of marginalised communities.

became more solid. This solidity began to create aspects of an entity that was partially responsive to its mechanisms through its participating agents and its systems of distributed intelligence. This made it possible to do political 'boundary work' within NENZ, while also requiring such work to ensure that the actants, such as people, objects, and information, were mobilised in the needed shapes and sequences of the NENZ 'mechanism'. NENZ represented the regional groups, not any particular person, yet it worked through a collaboration of individual actors and objects. Different arrangements and loyalties were possible. NENZ collectivised the groups, ameliorated some differences, and reinforced other differences. This mobilisation of representation offered greater potential benefits, yet also greater potential conflicts. As a participant, I had hopes, and took risks. I exceeded my formal authority as a CIVDURG representative, rather than risk the peer alliance being lost and the DISC Trust developing different goals of national co-ordination. If the NENZ proposal had collapsed later in 1995, I would not have been surprised, since there was no certainty to be found anywhere. Yet documents and objects began to move, commitments solidified, and organisation emerged regardless.

On a wider front, health professional types of goals and ethics are seen here to be entangled in market logics and expertise in budget management. It suited the Ministry officials and Nimmo to encourage the development of such expertise. The move repositioned peers from being only colleagues and competitors of pharmacies, to also being somewhat akin to 'pharmaceutical salespeople', a post-war professionalised occupation involving commercial expertise in a narrow range of commodified health products (Greene, 2004). Market expertise involved skills in contract negotiation. However, bureaucratic expertise in management was required to link personal skills, be those formal contract market or informal drug market proficiencies, with structured, stable organisations. This development shows how solid demand for peer-professional NEP services became meshed with a solid organisational capability, and in these ways, attained the status and resources of state agency funding.

3 Commercial logics, regional divisions, professional representation

In 1989 it was difficult to monitor syringes for HCV seroprevalence because the techniques required more blood than was usually found in returned syringes. By 1992, the voluntary testing of NEP clients had proved feasible and received peer-professional support, as discussed in Chapter 8. This method permitted larger blood samples, and in being workable, increased the professional and official awareness of HCV prevalence. Nonetheless, changes in policy were slow and were not based on previous models that presumed a national strategy. Instead, a range of 'action memos' were published during the mid-1990s, yet in 1997 a Ministry of Health official responded to

requests for increased funding by referring to HCV as a personal health rather than public health issue (NEP, 1997). This was despite HCV being a contagious disease that, as with HIV, would have far lower incidence if the 'pool' of persons with the virus in the community was reduced in numbers by treatment and prevention programmes.

Before 2001, according to a Ministry of Health official, there was no comprehensive HCV prevention policy (NEP, 2000b). Nor have health professionals published a comprehensive model of HCV transmission and treatment suited to New Zealand situations, and by which policy outcomes might be evaluated by specialist groups and the public. The founding NEP logic has been to increase IDU access to syringes and improve motivations to safer injecting practices by means of trusted intermediaries. Despite the prevalence beginning and remaining high among IDU, the NEP logic has remained the only strategy for reducing the incidence and consequent prevalence of HCV.

To increase access to syringes by IDU, the purchase price needed to reduce. The price was kept high by user-pays funding, and by rigid regulations. These regulations required that only value-added packs of syringes that contained printed educational material could be sold (CASONZ, 1990c). Officials in the Department of Health and the later Ministry of Health refused to address these problems, despite repeated requests from the peer groups. After NENZ became established, the peer-professionals attempted to reduce the purchase prices of syringes through two methods. One was to deregulate, the other to increase funding levels. As might be expected in a hybrid situation, the two methods frequently entangled.

Between 1990 and 1996, most peer groups had carried out illegal trials of at-cost or free syringe supply (Nimmo, 2004. pers. com.). These trials were ignored by officials, yet the significant increases in sales and returns provided evidence of barriers to access by IDU. Such trials were funded out of the existing peer group budgets, as a benefit to their IDU constituency. It seemed impossible for the regionally isolated and financially constrained peer groups to subsidise the cost of syringes, without reducing other areas of service provision such as managerial wages and volunteer expenses. These restrictions reduced the NEP goals of empowering the marginalised IDU communities by reducing the numbers and status of peer representation, and by 'isolating' the normality of peer-controlled activity within a limited compartment of the health sector.⁴⁸⁴

Data from the free syringe supply trials showed that pricing barriers compromised the NEP goal of always using a new syringe for injecting, yet also seemed to be unfair competition from the perspectives of pharmacists (Henderson, 2005. pers. com.). The NEP pharmacists were more professionally constrained by regulations and could not reduce their fixed prices. Yet these pharmacists did not want the NEP regulations changed to 'unfix' the prices, fearing budget uncertainties and the possibilities of disputes with IDU clients, as discussed in Chapter 5. Nor

484. See Smith (2003. pers. com.), Aitken (2002: 48-49).

could the pharmacists operate at a loss. Furthermore, by buying as a single bloc the peer groups benefited from economies of scale that were not available to individual pharmacists. Despite being normal in overseas programmes, free syringe supply schemes actually risked destabilising the hybridity between the pharmacists and the peers in the NEP.

In May 1996, the Drug Health Development Project (DHDP) peer exchange in Wellington, began a free one-for-one trial exchange organised by Robert Kemp. Over 700 IDU clients became registered (Kemp, 2004), showing how the demand from IDU overcame their needs for anonymity. This was the first financially sustainable trial because it was funded by the local Regional Health Authority (RHA). This official support also caused a potential problem, since the RHA was a state agency, and had been induced into 'inadvertently' breaking a law. The trial was halted, in extremely ambiguous and contested circumstances, in January, 1997.⁴⁸⁵ Two reasons have been offered. The trial had breached the NEP regulations that required a single, fixed nation-wide price. Furthermore, the trial had featured continuing requests for funding increases, which worried the officials concerned (Nimmo, 2005. pers. com.). Yet arguments continued and regulatory opinions shifted as regards the first rationale. Furthermore, NENZ member groups had reasons for supporting, yet also opposing the trial.⁴⁸⁶

The trial was supported because its data created an evidence-base for lobbying for free syringe supply,⁴⁸⁷ which was the single most significant goal of all the peer-professionals. Furthermore, the peer groups had contributed significantly to achieving cost reductions through wholesale purchasing of syringes, and insisted on these savings being passed on to IDU consumers, to help reduce access barriers. The trial supported this goal, even though the funding streams were different. Furthermore, the halting of the trial breached an understanding that breaking the requirement for a fixed price would be ignored if the new price was lower than the regulation price (Blacklock, 1997). Yet the trial also created significant problems for the NEP co-ordinator's attempts to recruit and retain pharmacies (Henderson, 2004. pers. com.; Nimmo, 2004. pers. com.).

Officials in the Ministry of Health tried to retrieve the situation by creating a special legal exemption for the prices charged, or rather not charged, by the Wellington peer group. This would have left the prices for the other peer groups and pharmacies far higher. The 'instability' this would have caused needed to be formally brought to the attention of Ministry officials by its legal division (Ministry of Health, 1996). The prospect of direct control of local price differentials would have startled many officials in the short term. In the longer term, the situation appeared very similar to

485. See NEP (1997), Blacklock (1997), Poutasi (1997), Ministry of Health (1996, 1999).

486. All NENZ members wanted to reduce the financial access barriers to reduce HCV incidence. However, there seemed a possibility that completely free supply might be forced by one-size-fits all regulations onto other groups unable to sustain the financial burden. This would have opened such groups to the risk of collapse and takeover.

487. Supply was emphasised over exchange because although return rates had seldom risen over 50%, there had been no reported problems from syringes being disposed of in public places.

how the peer groups started in 1988, with ADIO being initially an exception, then rapidly developing into a model of exceptionalism in an environment of contradictions that favoured the expansion of such models.

The DHDP free trial undercut the NENZ negotiating strategies, which depended upon stable national balances of costs and benefits. These became destabilised by a regional initiative that relied on exceptional funding and regulatory circumstances. Free exchange, funded by Government, was only achieved as a national policy in 2004, after a decade of official inaction, and only through direct Ministerial intervention that overturned previous Ministry policy. NENZ also needed to retain the support of pharmacists in order to provide national scope of NEP coverage. However, since pharmacists would not participate in any system that removed their service fee, free syringe supply required careful planning and gradual approaches. Such constraints, combined with an understanding by stakeholders that the overall funding requirements would not significantly increase (Ministry of Health, 2000), led to regulated price controls being replaced by downwards pressures in response to market conditions from 1998 (Aitken, 2002: 67, Ministry of Health, 1998b). Syringe prices dropped over the following year in gradual, manageable ways. At this time the DHDP withdrew from NENZ.

In order to reduce the syringe purchase price through a different method, Ministry officials and NEP peer-professionals wanted to reduce the packaging, transport, and disposal costs. This entailed shifting towards a more open market, less price-fixed system. Once single syringes had been able to be sold in the early 1990s, though not licitly, rather than only in packs that included a return container, the supply of empty safety containers became a significant unallocated cost. This cost was assumed by state agencies specifically responsible for public health. The peer groups began supplying pharmacies with syringe packs in a commercial distribution system. However, the peer groups used the profits to subsidise the public health aspects of the NEP, such as 'sharps bins' and personal returns containers (Kill, 1998) which had become increasingly difficult to supply (Blacklock, 1997). In return for providing free returns containers, NENZ received an informal undertaking from the Ministry in May, 1996, that: "price regulation would not be enforced if outlets priced below the recommended level" (Blacklock, 1997).

In 2001, NENZ developed greater bargaining resources due to a commercial expansion through a Ministry of Health service contract to transport returned syringes for disposal. There had been a period from 1993 to 1995 when no system for the recovery of returned syringes existed. This was due to the Ministry replacing the Department of Health in 1993, destroying the Departments systems of syringe recovery, but not replacing that system (Walker, Brady, & Baker, 1994: 2, 31). Matters were left to market forces. After 1994, under a scheme called Outlet Support Service, individual peer groups and commercial operators had been contracted to collect the returned

syringes for incineration in local hospitals. However, the scheme had been fragmented and difficult to manage (Henderson, 2005. pers. com.). Nonetheless, in 2001, the Ministry of Health suddenly needed to purchase waste disposal services for transporting the returned syringes when the regulations from the *Hazardous Substances and New Organisms Act* (New Zealand Government, 1996) came into force. These regulations increased the costs of transporting hazardous wastes by increasing the quality controls required. The disposal contract required the people transporting syringes to be appropriately qualified and to maintain a rigorous record-keeping system.⁴⁸⁸ In response, NENZ created a commercial subsidiary called Needle Exchange Services Trust (NEST) which employed three people. One was the NEP Co-ordinator, who supervised two driver/educators, one in the North Island and one in the South Island. This commercial yet not-for-profit activity made other NEP duties, such as political representation and advocacy, more stable and financially sustainable.

NENZ could undercut commercial prices, while offering pharmacy support services, by being dedicated to NEP outcomes rather than to profitability. The health and commercial expertise of NENZ aligned with the other hybrid professional aspects of the NEP, and with the expectations of Ministry officials. However, NENZ's increased bargaining capabilities extended its activities into the policy and budget setting spaces of governance. NENZ represented IDU in their being a marginal community, and as consumers of NEP services, and also as being a key factor in the provision of public health. Accordingly, potential policy challenges to the Ministry jurisdiction over health outcomes and health rationing became more likely. However, the health and commercial professionalism of NENZ had become aligned with the Ministry in a network of provisional trust and circulation of syringes and money. Any abrupt local shift in this network jeopardised the wider stability.

Conflicts between state agencies and peer consumer representatives emerged because service deficiencies were caused by the regulatory controls that held prices high and created access barriers. The prosecutions for the possession of NEP syringes had continued. The informal arrangements for the supply of sharps bins and returns containers were not honoured by new commercial entrants to the NEP syringe supply market (Blacklock, 1998). Such conflicts intensified because increased IDU access to syringes to reduce HCV transmission required increased resources. Yet the state agencies and peers had different understandings of the hazards and costs of HCV.⁴⁸⁹ In these later years the Ministry of Health proved reluctant to extend its

488. See Ministry for the Environment (2005a, b), New Zealand Government (2001).

489. HIV/AIDS has been accepted as a public health hazard. By comparison, from its emergence as a testable disease, HCV was addressed as public health where this overlapped with existing HIV prevention measures. Where such measures needed to be extended "to combat the further spread of the disease amongst IDU, ... [the Ministry of Health negotiator] responded that the issue was dealt with under Personal Health in the Ministry" (NEP, 1997). The 'public safety component' of the NEP included purchase and delivery of returns containers and sharps bins (Ministry of Health, 1999). These helped to prevent needle stick accidents to the general public, in contrast to the deliberate sharing of syringes, yet HCV could transmit in either case. This categorisation would seem to require

‘partnership model’ of harm reduction and community empowerment from HIV to HCV prevention.

The NEP transactions shifted around, ‘hunting’ for the most supportable arrangements. Commercial transactions that had been an IDU responsibility, as in the user-pays arrangements, became less influenced by profit motives and service fees, even becoming intermittently state-funded. The transactions, such as waste disposal, that had been a state agency responsibility, moved from an unsheltered external market environment closer to a less competitive, less ‘for-profit’, more professional position inside the NEP. In these developments, commercial expertise seemed effective and efficient, in contrast with the uncertainties associated with the peer representation of IDU. Peer influences had originally depended upon the NEP goal of motivation change. This goal had been heavily and systemically de-emphasised, with priority given to the economies of the movement of syringes by peers. However, as shown, syringes carried their own forms of representation, surveillance, and meaning. Peers became separated from IDU in the degree of control of syringe movements and associated surveillance, yet only partially. Because of the hybrid environmental needs, syringes carried a public health need for IDU empowerment, and peer-professionals wanted to empower IDU.

In becoming a single actor with a monopoly over the disposal of used syringes, peers had achieved a place at the policy table. Yet the increasing expenditure on the NEP gave the Ministry of Health increasing reason to distrust the capabilities of the peer-professionals for loosening budgetary purse-strings. Although the results of testing returned syringes in 1989, 1990, and 1994, had shown HIV to be controlled, the available information on HCV prevalence indicated increasing requirements for expenditure on treatment.⁴⁹⁰

In 2001, as frustration by peer-professionals, and a need for Ministry of Health officials to defend their policy jurisdiction intensified, conflicts broke out during negotiations over the ‘rescue package’ for the collapsed IV Union peer exchange in Palmerston North. The IV Union had exceeded its budget by running a free syringe supply, a problem perceived by NENZ as a symptom of a national issue that: “... levels of government funding under contracts are insufficient to provide the services which we [NENZ] collectively contract to provide” (Ministry of Health, 2001: 1). NENZ threatened to undertake rolling strike action at the thirteen peer group needle exchanges. This would have halted the supply of syringes and the collection of used syringes from all two hundred and eight outlets, amidst frenzied media coverage. NENZ wanted the Ministry of Health to

HCV prevention to compete for private health funding, and would prevent any comprehensive HCV minimisation programme. Perhaps nothing else so indicates how a communicable disease was not considered a public health issue when minimising the chances of accidental exposure left ‘only’ IDU liable to future HCV harms.

490. See Sheerin, Green & Sellman (2003, 2001), Easton (2002), Carter et al. (2000), Nesdale et al. (2000), Kemp & MacDonald (1999), Judson (1999), Kemp et al. (1998), Brunton et al. (1996), Robinson et al. (1995), Brunton (1994), Woodfield et al. (1993).

lobby for increased government funding to pay sustainable rates for the contracted services needed to improve the NEP health outcomes.

The Ministry of Health officials refused to negotiate outside of the existing budget constraints, acting as rationing agents rather than as community health advocacy agents. NENZ had acted to increase the funding of a peer group by invoking a concept of collective contract negotiation. This threatened both the Ministry bargaining position and the established governance system for the peer groups. The Ministry officials could not easily start up new peer groups outside NENZ without jeopardising the stability of the NEP. However, the NENZ collective stance also conceivably threatened the autonomy of those peer groups that were well-resourced, while offering benefits to the lower funded groups. The Ministry officials only avoided industrial action by promising to enter into genuine contract negotiations and guaranteeing that the NEP would be reviewed by an independent researcher.⁴⁹¹ NENZ insisted that the selected researcher be from outside New Zealand and otherwise outside the influence of the Ministry.

Shortly after the strike had supposedly been settled, an official wrote on behalf of the Ministry to NENZ stating that they had 'no confidence' in the NEP co-ordinator. Among other responsibilities, the NEP co-ordinator was employed to act as the primary negotiator for NENZ. The Ministry official also stated that they had lost confidence in NENZ itself, since NENZ members had voted unanimously, in an emergency meeting, to support the strike.⁴⁹² Such actions were not considered 'constructive and practical' by these Ministry officials.⁴⁹³ Shortly after this vote,⁴⁹⁴ these Ministry of Health officials negotiated privately⁴⁹⁵ with the DHDP group in Wellington for it to assume the management of the Palmerston North group. According to NENZ sources, Ministry officials had delayed negotiating over the Palmerston North contract until the exchange was financially irrecoverable. The IV Union in Palmerston North could not provide a viable alternative to being taken-over once it was unable to trade or employ staff. This seems in some ways similar to the CIVDURG situation described in Chapter 7, but without the outcome retaining local representation of local IDU situations through organisational autonomy.

Nimmo presented the issue as one of organisational autonomy, and requested an apology from the

491. As it turned out, New Zealand being a small country and the Ministry of Health very influential in any researchers career prospects, a researcher was recruited from Australia. This indicates the careful weighing of official influence necessary when evaluating state agency commissioned research in New Zealand.

492. Henderson (2005 pers. com.); Nimmo (2004 pers. com.).

493. The official who made this comment had previously been employed in the RHA that had supported the Wellington peer group trial, and had a connection with that trial. Nimmo had been reputed to have anonymously informed the Ministry about the trial, making the RHA involvement impossible to be ignored. Nimmo denies this, and has pointed out other reasons why the trial embarrassed its funders. A complex tangle of issues is clearly involved.

494. Some sources suggest before the vote, despite it being unanimous.

495. There has been some disagreement among the groups over the degree of private negotiation involved, but it seems clear enough that it was sufficient to surprise and anger other peer groups in NENZ. Whether the production of such division was a longer-term goal of Ministry officials has been impossible to track further, but does not seem out of the question.

Ministry of Health for overstepping appropriate boundaries in the internal affairs of private corporate organisations. No apology was forthcoming, in fact the Ministry officials made it clear to NENZ that, despite the strike being settled, they intended to pursue the matter by targeting the negotiator rather than the negotiation (NEP, 2001). A well-informed source reported that the NENZ Trustees were informally advised to drop the matter or risk further reprisals.⁴⁹⁶ Since the Ministry of Health funded NENZ, Nimmo had little choice but to resign.⁴⁹⁷

These conflicts among people, among peer groups, as well as between Ministry of Health officials and NENZ employees, all reduced the ability of the peer-professionals to trust each other. They also distrusted the Ministry, which had, for the first time, been seen to covertly intercede in the administration of a peer group (NEP, 2001). The Ministry was observed using its funding and regulatory powers to form a 'favoured' regional bloc, using external controls,⁴⁹⁸ in a way that undercut the legal autonomy of the peer groups and undercut the NEP's method of health promotion.

The Ministry file on the NEP contains no references to any workshops, discussions, negotiations, or other consultation with the NEP stakeholder groups in this shift to a new policy. Nor has any document on this new national NEP strategy been published.⁴⁹⁹ The Ministry perspective appears to have been that the peer groups had accepted an obligation to provide services, but did not have a 'right' to negotiate for improved services by threatening to withdraw existing services. Ministry officials, by contrast, reserved the right to negotiate with NENZ on the basis of excluding the peer group membership's choice of co-ordinator and negotiator. This conflict involved aspects of bureaucratic solidarity, opportunistic market negotiations, and a tangle of professional ethics.

The conflict problematised concepts of trust-based partnership between marginalised communities and officials. A decade of Ministry restrictions on service provisions, HCV prevention being treated as 'private health' rather than a general public risk to youthful drug experimenters and any drug user in prison, and inaction over continuing arrests of IDU⁵⁰⁰ for possession of syringes, had

496. This source is not named for obvious reasons.

497. However, Nimmo has also referred to the withdrawal of support by Karen Blacklock, another key NENZ spokesperson, as contributing to his resignation.

498. However, it must be kept in mind that ADIO had also started peer exchanges in other cities or towns and kept them centrally managed, also forming a regional bloc. The southward movement of this bloc has stopped at the level of Tauranga/Mt Maunganui. Such bloc formation relates to a NEP issue of service gaps and regional coverage that has been of concern since the peer groups began. Yet these are political blocs on the NENZ Board, not actual service delivery blocs providing adequate coverage on the ground.

499. These breaches of the principles of open and transparent government are of concern since, if a small cabal of officials within the Ministry decided to dictate policy for reasons of personal interest, or to cover up previous malfeasance, the outputs would be similar. Such situations of uncertain trust do not seem conducive to effective and efficient management, especially in situations where distrust is endemic, such as the intersections between crime and health promotion in the NEP.

500. NENZ collected details and aggregates on such arrests throughout the 1990s. Despite supporting the 1987 legislation and statements of support for the programme, police also desired to retain their powers of arrest. The ability to harass IDU with holding charges aids police abilities to gather information, even when no serious intent to lay charges is present at the time of arrest. According to Ericson & Haggerty (1997), information gathering is the core activity of policing.

minimised peer-professional trust in Ministry officials, none of whom remained from the NEP's formative period.

The NEP peer groups attained a long-standing goal through the strike, since the settlement initiated a fully independent external review. This was carried out by researchers from Australia who had no record of strong links with Ministry personnel, nor career interests in receiving future commissions from the Ministry.⁵⁰¹ The report from the review recommended the provision of state funding for a free, one-for-one syringe exchange system. The quality and public nature of the review (Aitken, 2002) could not easily be ignored, yet even so did not lead to decisive action by the Ministry.

Ministry inaction notwithstanding, the review helped to gain the support of the Associate Minister of Health, who was politically and philosophically disposed to the concept of free provision of essential health needs. The review provided sufficient evidence to justify the expenditure on a Ministerial-directed policy goal of a free one-for-one syringe exchange system. The combination of authoritative public evidence and the Minister's 'private' influence over policy overcame the official resistance to promoting a free, one-for-one exchange system as a goal. The previous record of Ministry officials suggests strongly that the NEP review and the free one-for-one scheme only occurred because of the strike threat, which Ministry officials themselves attribute in significant aspects to the NEP co-ordinator, Simon Nimmo.

Nevertheless, the free one-for-one scheme itself has changed the interplay of stability and uncertainty from which the NEP's sustainability has previously emerged. By becoming more dependent on centralised government funding, the autonomy of the NEP outlets has been reduced. The acceptance of centralised funding would seem to entail increased control by state agencies over the ways in which the funded services were provided, along with increased vulnerability to swings in government policy, as illustrated by difficulties experienced by Australian needle exchange groups (Kemp, 2003; Brunton, 2005. pers. com.).

A significant degree of financial independence had for a decade helped peer-professional groups to negotiate with rather than be directed by first the Department and then the Ministry of Health. Even though NENZ itself was centrally funded, its threat to strike shows that its policy was directed more by its members' needs than by a concern to appease the hand that fed it. The strike led to the loss of a skilled and spirited NEP administrator. Nonetheless, the hybrid health parameters of the NEP seem just as risky to exceed by becoming overtly politicalised as by being overly peer, or overly professional. Yet I consider that the peer-professional groups would have achieved much less if they had been directly employed or otherwise more closely administered by the Ministry, since they would have fewer options to propose unwelcome policies, to adopt independent stances,

501. I would be far less likely to have written this social history if I was a young social technician type of researcher wanting to specialise in health analysis in New Zealand, and looking to forward my career at any price. Fortunately for this research, I can be honest because I am independent in years, resources and most of all, in attitude.

to disobey superiors, and to demonstrate their expert capabilities. The NEP gained significant capabilities of community empowerment and providing health services by surviving as a independent, commercially accountable type of semi-health professional. I do not consider that these widely distributed and rapidly adaptive capabilities could have been achieved through any central or regional administration that was associated with close direction by state agency officials.

4 Alliances and antagonisms between government and governance

I have described how the NEP's forms of community representation and health provision were sustained, largely through increases in stability but also through sudden changes, by means of a commercial infrastructure constituted by a combination of syringe transport, peer employment, and professional practices of accounting and administration. Yet this was not an open market environment. For most of the NEP's history, the purchasing, transporting, and sale of injecting equipment occurred within a highly regulated framework. Such regulations could not be formally disregarded or broken, because they sheltered NEP activities and personnel from the criminal law that prohibited illicit drug use. Nonetheless, these regulations were frequently ignored in practice, or worked-around in discrete complicity with state agencies. This flexibility came from the distance and discontinuities of administration, and from the legal autonomy of the peer outlets, backed up by expectations that services would be provided using commercial methods, as in the initial planning around a pharmacy system.

A 'shop-front' dispensary model of exchanges run by peer groups consolidated alongside pharmacies because an improved supply of syringes seemed an achievable goal for a type of public, 'non-closeted' IDU who desired better health outcomes for their peers. A peer-run shop could provide printed health information alongside the sterile injecting equipment that IDU desired. Peer-run shops seemed capable of delicately altering IDU social networks by creating a resource and support centre, while not increasing media problems, nor unforeseen political costs, since a public shop could not permit any private activity of injecting on its premises. The shop 'activity' did not involve point-of-sale, peer-to-peer counselling. It only influenced IDU motivations through understandings gathered from printed educational material, or more pervasively from the way syringes as objects became normalised and rationalised. However, the shops did provide a stable environment where peer-to-peer services, and peer empowerment as health specialists, could become associated with and supported by syringe logistics. This stability was reinforced by the minimising of financial costs to the public partly through the user-pays system and partly through avoiding a bureaucratic system of administration that depended upon officials.

The NEP overcame the difficulties of its institutional environment, and of the more short-term

public urgency over HIV/AIDS, by consolidating as a simple, workable concept. By becoming workable, the difficulties became the foundation of the NEP's productivity. Nonetheless, such difficulties explain some of the rigidity of the eventual Management Plan. As the plan consolidated, the difficulties and opportunities for opposition increased because more details could be specified and opposed, both empirically and symbolically.⁵⁰² At this stage it became useful to reduce flexibility and enforce rigidity, satisfying one set of stakeholders while challenging a different set who could not be satisfied to accept the plan as an non-modifiable whole, or to reject it and therefore become accountable for proposing a workable alternative.⁵⁰³

After 1988, as the NEP extended in corporatising and professionalising with the emergence of the peer groups, a more flexible hybridity emerged as the regulatory framework was ignored, or informally modified, then eventually rescinded. The commercial logics and practices that first accompanied then superseded such regulatory directives facilitated the further consolidation of peer-professionalism. This was partly due to the neo-liberal funding and policy environment, and partly because the longer the NEP offered cheap and effective health outcomes, the less public support was needed from the medical professions.

The peer-run shop-front model had not been present when the requirements by police and medical professionals for IDU counselling had initially been formalised. The model emerged through a bending, shifting, and reassembling of strands, some illicit and some professional, into a new configuration of peer-professionalism where IDU self-help methods remained significant as an alternative.⁵⁰⁴ However, the well-organised movements of the syringes and other objects added stability and reliability to the institutional configuration of the NEP's necessity.

As the NEP adapted to an increasingly neo-liberal state sector environment during the early 1990s, its activities became differentiated into several layers of contractual arrangements. These connected a grounded network of IDU practices with high-level policy decisionmaking, yet simultaneously distanced IDU from direct supervision by state agencies, while providing spaces for self-directed NEP activities. The peer-professional representatives of IDU occupied and stabilised these spaces by forming alliances among state agencies, several health professions, and IDU.

502. For instance, when the Management Plan was publicly presented, the AIDS Advisory Committee could directly criticise its lack of obligatory exchange and professional counselling, but not before. Furthermore, pharmacists were concerned to minimise unpredicted cost increases.

503. Whereas in some policy-making of this strategic type the urgency is carefully engineered, for instance by interested officials holding agendas who thereafter can claim to be disinterestedly following their 'neutral' due process in directing the consultative mediation between public and private interests, in the case of HIV/AIDS the urgency was genuine.

504. Syringes were moved initially along grass-root networks, then by illicit pharmacists, then by licit pharmacists in the NEP, then by IDU peers, then by sex-work peers, then by 'Key IDU' in the West Coast pilot programme. By 1995, ADIO openly provided twenty different combinations of needles and syringes, quite illegally, yet purchased in an open market with the knowledge of the Ministry of Health (Ministry of Health, 1996). In 1998, somewhat unbelievably, and seemingly with intent to mislead, police claimed that "there is still a market in stolen syringes and needles" (Ronald, 1998). Any such theft seems irrelevant, except as an alternative, self-help measure by IDU that would become significant if the NEP did not exist.

Peers did not 'leap' into these spaces of opportunity; rather, they followed a retreating professionalism to which they remained attached, and to which they attached their NEP variety of peer-professional concerns. This social resource developed by inverting illicit, inappropriate knowledges and practices, then extending the resultant productivity into wider network activities that were successfully translated as appropriately healthy, within boundaries.

Although the transport of sterile and used syringes became increasingly organised and 'professional', the general terrain of IDU trust and distrust remained largely unchanged due to the continued prohibition of drugs. Boundary lines were shifted, but only in local sites that remained local. The NEP was frequently described as a success story for harm reduction policies. Nonetheless, the NEP, considered as a site in interactional spaces,⁵⁰⁵ did not demonstrate any significant capabilities of extending its environment by demands 'from the inside'. Instead, openings to territory emerged from the outside environment of commercial, official, and professional practices.

Useful descriptive concepts can be found by following the actual connections that constituted the NEP's hybrid network. We can see how boundaries of insideness and outsideness followed the materialities and logics that made some arrangements more possible and desirable than others, depending on the positioning of the actors in their adaptive networks. The syringes moved from health territories and practices of control to illicit zones of deviant or informally contested control, then circulated back again as returns that constituted an implicit trial of intersecting goals and complicit rationales of control. Yet, since this circulation was achieved through commercial logics and practices, the institutional boundaries of crime and health lost some definition and coalesced somewhat towards a less distinctive 'normality'.

The NEP's development has involved both the extension and consolidation of its forms of activity. By extending its communicational linkages to allied AIDS Service Organisations, such as the NZAF and NZPC, the NEP could draw on two models of organisation that offered different forms of peer support against national, institutional types of difficulties. By contrast, the consolidating of a regular, controllable movement of syringes across the internal-external boundaries of the NEP provided an internal cohesiveness from its specific mechanism and organisations, rather than only as a programme. The original pharmacy-based NEP consolidated in two ways.

First, its hierarchal structure of governance and surveillance by officials tended to already be singular and centralised, despite local differences in environment and enforcement. Certainly, local AIDS co-ordination committees were added to these pre-existing pharmacy monitoring systems. The Christchurch Committee was recorded in CIVDURG logbooks as significant in facilitating the

505. Peer needle exchanges operated in an increasing number of types of places, and with different hopes for counselling and/or peer outreach. However, there has only been a single set of regulations and one model of commercial and record-keeping practice.

local AIDS service organisation and health sector networks.⁵⁰⁶ Nonetheless, there are very few records of such committees communicating with the AIDS TaskForce. It is possible that there were few unmet co-ordination needs at a national level, unlike during the later periods of the NEP.⁵⁰⁷

The second form of consolidation involved the way infrastructural problems and oppositions were successfully addressed, worked-around, or resisted, at the NEP's middle and late planning stages. In this second way, problems were solved or moderated through reconfiguring processes. For instance, fragments of official bureaucracies were combined with webs of commodity exchanges and IDU drug markets. The connections that constituted the environment of assemblages were added, removed, or modified in their positional activity. Each connection contributed to the boundaries of understanding of the participants who maintained their structural environment through everyday occupational relational interactivities. Yet each connection also contributed to a path-dependent, materially solid, locational environment. Path-dependent factors limited what could have happened. However, not everything that could have happened did happen (Abbott, 2001), because the connections were influenced by chance and human agency. Some connections occurred at a specific time and place because a specific people with motivation, resolve, and skill occupied a suitable place during an opportune time.⁵⁰⁸

The initial geographical boundaries of the peer groups were decided in an environment dominated by pharmacy practices. The peer groups then became dominant in terms of driving the changes in NEP policy, yet the NEP pharmacies remained essential en mass, because the small numbers of peer groups could not provide national coverage.⁵⁰⁹ The NEP pharmacies in the small towns and rural areas remained essential, while those in the cities remained in the syringe business only by providing services to IDU who had a choice to go elsewhere. However, the pharmacies existed in a commercial environment, needing to make a profit to cover wages and overheads. Localised experiments in free supply, from a perspective of a pharmacist's professional ethics, constituted shoddy business practices. Significantly undercutting a fellow professional's cost-plus pricing structure was morally unacceptable to pharmacists, yet some NEP peer managers who were oriented more towards political and official alliances, at times overlooked the need to maintain this crucial connection between health and commercial professionalism. The free one-for-one system that was introduced in 2004 required NENZ to reimburse pharmacists for their NEP contributions, and otherwise offer formal recognition of the difficulties faced by pharmacists.

506. This was in Christchurch, which has high levels of health sector networking. Other cities could have been different.

507. It may also be that the pharmacists in the NEP remained centrally co-ordinated through the pre-existing hierarchy of officials, such as local Medical Officers of Health and District Advisory Pharmacists, as well as the professional bodies of the Pharmacy Guild and the Pharmacist Society. The Guild represented the commercial interests of pharmacist practices, the Society represented the professional interests of qualified pharmacists.

508. We see this in Bruce Burnett, Gary McGrath, Rodger Wright, Michael Baker, Redmer Yska, and Michael Bassett. Later we see Robert Kemp, Simon Nimmo, Catherine Healey, Stephen Lungley, and Nigel Dickson providing key influences, links, research, and decision-making.

509. See also Appendix 7, where a condensed history with statistical data is summarised.

As the peer groups' outreach focus was supplemented by a syringe supply focus, then by a research and surveillance focus, then by national co-ordination through federating, their professionalism in health promotion increased, yet was largely stabilised through their shop-based, commercial professionalism. They extended their activities from isolated shop-front outlets by means of increasing their control over syringe supply, coming eventually to run the syringe disposal collection system. Their product of appropriately packaged and understood syringes was in high demand with no alternative, yet was also highly price sensitive since the reuse of syringes was easy and familiar to IDU.

The proposals for regional management blocs made little sense in the NEP environment, since the problems that the NEP initially focused on were understood by participants as local or national, rather than regional. The transport of syringes between national and local sites was adequately addressed in commercial practices that did not require nor wished to afford the overheads of regional administrative blocs. A thick administration would have provided for training of a greater number of mid-level personnel. Yet it would have been harder, if administrative rather than representative logics applied, to ensure that these were peer professionals rather than other types of administrators. However, a national professional body that represented local groups, and by extension local IDU; that set standards and controlled entry into this market; made a great deal more commercial sense.

Higher-level state agencies were accountable for enforcing the constraints over the NEP funding and maintaining general jurisdiction over NEP policy. These agencies had interests in protecting their policy and strategy turf. Yet, the succession of officials who implemented these accountabilities also needed the NEP to work effectively and efficiently. This co-ordination required a national network of communication linkages, within a mutually agreed upon system of specialised roles and accountabilities, closer to sites of implementation and commerce than could be supplied by a governance-only Ministry of Health. From this perspective, a national co-ordination body also made sense.

Both the Ministry of Health officials and the peer-professionals came to simultaneously support and undermine the NEP in the process of constantly producing its stability from a changing heterogeneous environment. Paradoxically, the achievement of greater stability led to instability, since peers came to shape the negotiating environment through their control of commercial infrastructure, while being vulnerably isolated in their public activity of representing IDU. Their commercial accountability and expertise provided the stability and connective linkages that sheltered the autonomous groups from their isolation and closeness to the often chaotic IDU environments.

As the NEP's co-ordination centralised, such shifts were accompanied by changes in representation. The state agencies that handled the NEP's funding contracts became first de-centred in shifts from the AIDS TaskForce to Regional Health Authorities. From then the agency oversight increasingly reverted to centralised controls over contracts. Yet this was at a higher, more remote level of governance where officials were less familiar with the history and specific sensitivities of NEP work. As awareness of hepatitis C prevalence belatedly increased, in terms of the national financial and political risk, the sites where funding was negotiated moved closer and higher to the level of the regulatory and policy-setting agencies. Meanwhile, NENZ became more engaged in facilitating service provision, arranging for a syringe returns service, and negotiating to extend the national coverage of the NEP's locally-centred, peer-based services. The stability and effectiveness of the mid-level co-ordination of NENZ led to increasing influence over policy, and accordingly, to extend up and into an inherently professional type of territorial conflicts with a policy-protective Ministry of Health.

The crisis erupted when it did partly due to inflammatory media tactics by several peer-professionals in Palmerston North, but also because NENZ acted overtly in its representation of the collective autonomy of the regional peer groups. This act of representation 'flattened' the hierarchal distances and stages that presented boundaries excluding the individual peer groups from the Ministry of Health's 'property' of government. As with the earlier concepts of bulk-funding the peer groups, this representational activity threatened the autonomy of the stronger groups, which were better positioned to establish mutually satisfying relationships with their local funding agencies.

NENZ's move also threatened a previous state agency tactic of divide and rule. It threatened long-standing desires shared by health officials and some like-minded NEP peer-professionals for solidly-established regional blocs which would occupy the places and space between urban peer groups and a single national co-ordinating body. There was no need for 'thick' mid-level blocs if NENZ provided regional services that covered the gaps between the city-centred peer groups, yet NENZ was beginning to provide just such services through NEST, its syringe return subsidiary.

The capability for collectively funding negotiations that NENZ potentially offered would, if successful, increase its viability as a preferred model in both the commercial and health senses of professional service delivery through peer-professional governance. The logics and practices of peer-professional environments and goals usefully explain much about the strike threat and resulting negotiations. This peer-professional account, emphasising the hybridity of the networked environmental conditions, seems more explanatory than any concept based only on strategising by individual personalities, or by particular interest groups.

Two periods of political connectivity stand out. The first, between 1988 and 1995, was shaped by the ADIO model supplanting the IV League model, then consolidating as a loose assemblage of five isolated peer groups. These groups were locally different but shared an equivalent role in a commercial infrastructure based on a user-pays, demand-driven, syringe supply system. Central co-ordination lapsed rather than increased over this period. The second period, after 1995, involved increasing co-ordination by NENZ of a formal federation of the peer groups. During this later period the NEP's national capabilities began to increase, while conflicts intensified between several models of peer-professionalism.

In the first period, health and commercial logics continued to differ, and accordingly, continued to produce their hybrid peer-professional stability between, rather than amidst, local and national aspects of the NEP. In the second period, regional arrangements with other AIDS Service Organisations and bureaucratic agencies increased the regulatory scrutiny, reliability of funding, and overall central control of the NEP.

Nonetheless, the regional arrangements at times resisted becoming accountable to NENZ as it developed as an autonomous professional body that represented both its member groups and the NEP's IDU clients. Such divisions were expressed in historical incidents, but were shaped from a mix of political and geographical boundary activities. During each of these two periods, different geopolitical administrative blocs were proposed. Overlapping sets⁵¹⁰ of NEP actors desired different types of commercial, educational and outreach activities, quality of coverage, local IDU responsiveness, and professional standards of accountability.

The political traction of NENZ was not supplanted, unlike the case of the IV League, which the Department of Health excluded from funding and influence in the same period that it contracted ADIO (National Council on AIDS, 1988b: 6). Instead, NENZ re-configured ADIO's 'outreach clinic/shop-front' concepts into a more workable form. NENZ drew more on IDU moral norms, seen in the IV League principles of mutual benefit, egalitarianism, and professional health delivery, yet increased its competencies by emphasising and extending the commercial pharmacy norms. The result was both peer and professional. It depended on grass-roots IDU participation, yet was autonomous as an organisation, and was nationally co-ordinated in collegial ways that combined egalitarianism and specialisation of expertise. Most significantly, this combination only provided sufficient stability to align its different elements into a more productive mechanism, not to reformulate them into a non-conflicting, non-paradoxical, clearly-bounded machine-like whole. The latter goal, of union rather than an exceptional mechanism of alliance, was understood by all the NEP actors to be unworkable in the wider institutional environment where drug injecting remained highly individualised and criminalised.

510. Such sets might further consolidate and become distinctly different, but that has not happened before October 2007.

The NEP's increased commercial efficiencies and managerial expertise have assisted in the delivery of peer-professional services, such as providing representation, advice to state agencies, input into training in related fields, IDU support and research, along with the development and monitoring of models of motivation change (Keene, 1997: 150-2). Nonetheless, commercial practices also worked against one of the crucial methods of influencing IDU motivations. The peer groups initially relied on volunteers who were informally reimbursed 'under-the-table'. However, over time, the NEP's employment practices became more professional, either self-impelled or as required by the *Employment Contracts Act* (New Zealand Government, 1991).

Pressures from the wider environments of employment law and professional best practices of employment led to IDU volunteers becoming legally employed as workers. Because this legal compliance was more expensive than the illicit reimbursement methods, it drained the limited budgets of the peer groups. According to standard commercial logics, the overall numbers of peer personnel were decreased unless extra funding could be found. In consequence, the informal outreach carried out through the personal networks of peer volunteers shrank, and has been linked, by one peer-professional manager in Dunedin, to a levelling of the numbers of syringe sales (Richardson, 2004. pers. com.).

The opportunities and problems of informal outreach have not appeared significant because the numbers of IDU participating in the NEP has not been a standard output in the funding contracts, while such funding has increased in importance compared with the user-pays funding. This example illustrates how the hybrid mechanisms of the NEP involved social, commercial, legal, and professional logics, such that privileging any single logic actually altered the whole mechanism in a seemingly irrational, unpredictable manner. More specifically, oppositions between empowerment through formal employment, and outreach through informal networks, seem to characterise the peer-professional hybridity of the NEP. This innate opposition in the midst of productive combinations renders the administration and co-ordination of the NEP a matter of complex uncertainties that require a professional type of discretionary expertise.

The peer groups were encouraged by the logics of a hybrid niche created by the NEP to become more professional, without losing their 'peeriness'. As professional health promoters, they shared concerns with doctors. Because they were more illicit and stigmatised, they could not afford to lose their 'health shelter', even though this was where the injecting practices and drugs they represented in the form of IDU communities were medicalised. The peer groups needed to ensure that their activities did not move outside their sustaining hybrid niche when they threatened the Ministry of Health with the media publicity of a strike. This is why the hybrid, not-for-profit health goals of the NEP have been largely accomplished through the supply and return of syringes. This commercial activity effectively and efficiently expanded the NEP niche environment. In so doing it it expanded

the scope and scale of peer-professional activity as representatives and policy entrepreneurs.

As the NEP environment moved from IDU grassroots and pharmacy sites to include corporate forms of peer organising, the connections between commercial professionalism and professional health goals became more politicised. This was partly because the ‘moral spaces’ (Plumridge & Chetwynd, 1999, 1998) and the motivations of the interactions of the IDU, commerce, bureaucracy, and health professionals were different, and only changed slowly if at all over the period in which the NEP developed. What seemed appropriate for IDU differed from the expectations of a official employed by a state agency, or of a health practitioner who was accountable to a professional body. It was also partly because of place. An IDU in a kitchen with friends and syringes was different from an official in a meeting room with file documents, or a doctor in a clinic with a patient and syringes. Even if the same person was simultaneously an IDU, an official, and a doctor, the material environment, appropriate technologies, meanings, and possible performances were different.

This chapter has explored how two types of somewhat opposed professionalisms were made mutually supportive. Peer-professional health practices provided the sustaining goals and legitimations, while related peer-professional commercial practices provided the shaping and stabilising resources. The systems of transporting syringes produced a characteristic infrastructural stability, together with frameworks of understanding for explanatory and evaluative accounts. These practices of connectivity reinforced rather than eroded the institutional boundary lines which the NEP mechanisms had been founded to partially evade and locally re-work. Some connections became turning points (Abbott, 2001: 296-7), or at least sufficiently intense to draw the interactants involved from a pervasive background to a smaller and more distinctive foreground. It would seem that as the spaces for manoeuvring or evasion shrank, the boundary activity became intensified (Abbott, 2001: 292-3). This seems a partial explanation why the NEP peer-professionals remained hybrid without coalescing into, or being replaced by, a clearly understood profession, or by becoming employees in a bureaucratic infrastructure.

In the following inter-chapter I explore how such developments appeared from the perspectives of two individual peer-professionals. Their concerns illustrate key aspects outlined in this chapter, yet emphasise the complexities and differences that a more abstract overview risks overlooking. The following inter-chapter leads to my final section, where I make an argument for a hybrid model of the NEP in chapter 10, enrich this model by arguing for a specifically peer-professional principle of organising in chapter 11, before concluding with wider sociological reflection in a Coda.

Intersections

Dialogue

I have presented IDU as rational actors whose attitudes to the NEP and peer-professionals have been conditioned by necessity. However, because IDU have resisted being evaluated and modified, we cannot generalise beyond their substantive durability as a group and their pervasive rationales for distrust. Surveys carried out by the NEP produced few complaints from IDU clients. However, many clients would have no international experiences with which to compare the New Zealand NEP. We know from such surveys, and from the proportion of clients who used pharmacy exchanges, that IDU clients generally approved of the 'peeriness' and professionalism of the peer groups, but we have less idea about the range of perceptions, interests, and positionings of IDU. For instance, no studies have selected IDU with international experience that could be compared with local experiences, nor for IDU with professional health or social work training. The messy actuality of the shop-front outlet models, the peer attempts at motivation change, the empowering of marginalised communities, and the commercial infrastructural capabilities are seen to be entangled and problematic. Previous studies have not attempted to specify how and where the peer and professional aspects should be mixed or held apart in analysis.

To illustrate how this issue of divergences is significant, and more so in supporting a common theme underlying such differences, I will present the comments of several Christchurch peer-professionals. This 'constructed conversation' is intended to pull back from the intense problems and isolation of the initial Christchurch peer group by emphasising de-localised, reflective voices from amidst the NEP developments. These voices contain significant information which has been brought out by selecting particular thematic sections and placing them in juxtaposition. I selected the voices for their depth, coherency, relevancy of content, and being expert rather than random.

In 1989, IDU knowledge about HIV/AIDS was surveyed (Lungley, 1989: 3-4). IDU were asked who they would recommend to their peers for information on HIV/AIDS. The most cited sources were the AIDS Clinics and the AIDS Foundation (NZAF), as well as the AIDS Hotlines, drug clinics, and personal doctors. Although having operated for only a few months, the Auckland Drug Information and Outreach peer group (ADIO) was frequently cited by Auckland IDU. The study concluded that: "As a rule IVDUs seemed to prefer what they saw as professional advice. However many seem to see ex-users belonging to self-help organisations as "professionals" in their own way" (Lungley, 1989: 3-4).

The association of HIV/AIDS expertise with the NZAF, clinics, and treatment specialists clearly indicate a desire for a professional quality of health information and services. Yet during the 1990s, the NEP's expertise in moving injecting and educational products became comparatively more influential and professional than the 'education and motivation change' aspects of its work.

Because the central co-ordination and direction by state agencies began to lapse, because regional peer groups found that IDU lifestyle associations sometimes hindered attempts to professionalise NEP services, and because funding contracts prioritised those outputs that were easily measured, the NEP's regional infrastructure became noticeably commercialised. As one regional peer administrator reminded his Trust Board: "We DO NOT just sell needles and syringes, WE SELL SAFETY" (DIVO, 1994e). Consequently, the 'shop logics' of equipment logistics became allied with the public health logics of providing safer material environments and motivations towards safety. This alliance assimilated the motivation change logics of organising formal outreach activities outside of the exchange premises, leaving only the informal networks of peer workers to effect outreach. A NENZ Trustee commented that:

I think they do the exchange thing really well. I think the retail component in needle exchanges is good. ... [But] I think the people that are accessing needle exchanges generally are ... already converted. Outreach to me is getting to the people who aren't converted ... [retail alone is] not really getting to the heart of it.
(Jang, 2003. pers. com)

How is the heart of quality outcomes to be found? Retail and service competencies are often termed 'professional', even though they are achieved through bureaucratic organisation and commercial motivations. 'Profession' may refer to a particular type of social entity, or method of organising, yet also to general characteristics of care, quality, and accountability. That the NEP peer-professionals developed a commercial infrastructure seems crucial for understanding how the goals of outreach changed along with the capabilities negotiated between NENZ and the Ministry of Health. The connection of commercial to official and professional logics explains NENZ's representation of a marginalised client community, partly as accountable to, yet also in opposition to state agencies. Producing such connections required the active participation of a multiplicity of actors who co-ordinated their activities through linked stories together with linking objects.

Everyday IDU perspectives can illustrate how aspects of IDU peer trust and commercial trust are not self-evident. For one thing, IDU do not necessarily like or trust other IDU, and are not necessarily opposed to orderly arrangements. Some IDU would prefer the option of a centralised, highly commercial, and bureaucratised service delivery. 'Penny', a personal friend, is a 30 plus New Zealander, self-assertive, well-educated, and computer-literate, who has injected drugs in European, Australian, and several New Zealand cities. Penny preferred to purchase drugs from gangs in a commercial environment than from fellow IDU in an IDU peer environment:

You went in there and you bought what you wanted and you walked out! I just loved it! ... I thought it was [pause] sort of nice that you could go there any time of the day, and umm, no hassle ... It was run by a gang [pause] a bit intimidating at first [pause] but once you found that they weren't there [pause] to cause trouble, they were only there to make a flippin' lot of money ... once I got into the 24 hour drug shop I didn't need to associate with anybody else, and that was great! Then I didn't need to [pause] hang around with these people that I thought were complete horrible arse-holes ... and pretend that I liked them ... just to get some bloody gear.
(Penny, 2003)

'Penny' trusted a transparently commercial situation where interactions were stable and motives

were overt, in contrast to the uncertainties and repelling aspects she experienced in some IDU social interests and interactions. She disliked the lack of social competencies she found in some IDU networks in a particular city. A different peer-professional identified how market problems of supply, which encourage small self-protective groups forming around a regular pharmaceutical drug source⁵¹¹ are compounded by the social complexities of IDU networks:

In [the same city as Penny] people gossip and back-stab in IDU circles if one is not present. This is a reason for reducing the number of supply circles. If you have only one you are least vulnerable to not being present, especially when drugs are being sold and distributed and shared. You rely on friends to defend you in absentia ... but if it is a social situation of distributing drugs, they cannot be relied on very much. ('Nathan' 2004)

However, Penny preferred the 'clinical' non-peer aspects of a European needle exchange to her Christchurch experience:

I hated the Needle Exchange down here [1997], hated it, absolutely thought it was full of bullshit. Didn't like going there, didn't like having anything to do with them. ... the system they have in Europe is so beautiful, and so brilliant you can go and get your syringes and take them away if you want to ... [but] there's a great big cafe first of all, and you can get a dollar meal. You can get a great big feed for about a dollar. ... in the injecting rooms they always had at least one nurse, who supervised the whole thing and ... handed out your syringes ... everything was absolutely sterilised ... what that was saying to me was ... if you want to look after yourself, eat, and have safe injecting, and use completely clean syringes, we can help you do that, you know. ('Penny' 2003)

Penny seems to me to have wanted controlled and professionalised safe injecting practices. Such control has sometimes been associated with intermittent or recreational IDU. Jang considered that the people who lacked the control, or motivation, to use needle exchanges constituted an unmet outreach requirement. By contrast, IDU with dependence problems have often been fixed under an institutional, clinical gaze. Such IDU become represented in textbooks on drug treatment as irrational and without capabilities of choice, or inherently self-destructive, since: "Too often the act of taking drugs is no more than acting out their desire to destroy themselves" (Grmek, 1990: 168).

However, such perspectives require contextualising. Penny, for instance, had experienced serious addiction several times, suggesting recurring difficulties in her control of drug use. She disliked the NEP site where outreach was provided by her formal peers. She would presumably have greater resistance to motivation-changing influences at that actual site. Yet Penny continued to use NEP services during 1997, purchasing from the peer exchange she disliked rather than pharmacy exchanges. She used the NEP services in a controlled way and wanted higher quality services. Her experience of the peer exchange made her uneasy and distrustful, yet she trusted pharmacy exchanges even less. Penny was sensitised to the risks of being forced into a system:

where, ok its just legal to have a needle exchange but everything outside of that is completely illegal. You can walk in there [New Zealand exchanges] and walk out and just about get arrested, you know, which is what they can do and still creates a little bit of that, umm, suspicion on the drug user's part ... (Penny, 2003)

511. See Newbold (2004: 65, 2000: 181), Kemp (1996: 154).

Penny and Jang expressed different perspectives on outreach priorities, yet these are aligned in significant ways, despite their different positioning as actors. Penny was not actually saying what she considered ideal in theoretical terms, but rather what in her actual experience had been the service that best met her needs. Jang was more professionally positioned in terms of his goals being framed by theory, yet also drew on personal experience as an ex-IDU, as a qualified social worker, and as the administrator of an outreach/education/support organisation.

Both Penny and Jang appreciated commercial effectiveness and efficiency, provided that was not also associated with impediments to motivation change, such as distrust. Both considered that any enforcement of abstinence through law and treatment regimes reduced the effectiveness of outreach. However, Penny thought that outreach might be usefully sited in a clinical centre, and this would meet her needs. For John, outreach would be ideally present wherever injection was taking place, rather than relying on IDU presenting themselves at a peer group's premises:

I don't think the person doing outreach needs to be a non-user, needs to be a non-current user. I think ideally they should still be users ... people that use don't trust people that don't use. And that's even people who may have used before, ... there still is a bit of being unsure... It doesn't work. You know, they're [persons qualified as drug counsellors or coming from 12-step experience] sitting there, in a harm reduction agency, and they're coming from an abstinence viewpoint! ...
(Jang, 2003)

This ideal of outreach could not be limited to just a centre, and could not even legally occur in New Zealand NEP premises. Penny would seem to have no objection to IDU peers providing medical centre service, so long as being professionally effective and efficient was more important than just having peer experience.

From an actor-network perspective, these participant accounts about trust illustrate how the same objects such as syringes are active in different ways, when moved according to different organised logics, in different institutional environments. Syringes are different as actants because their network positioning means that they act differently. The interactions between their inscriptions,⁵¹² the people connected to them, their drugs, and their viruses, perform⁵¹³ differently. Such variability partly derives from their participation in commercial logics and expectations. However, that variability also alters the commercial feasibility of exchange through affecting supply and demand factors in a heterogeneously networked environment. Illicit exchanges have seemed inherently

512. Inscription is an actor-network term that refers to two activities. One, of 'inscribing', is of meaningfulness, where an object is symbolically laden and interactive in a communicative environment of symbolic understandings. The other, of 'scripts', is of productive constraint, whereby the physical possibilities of interaction are enhanced or constrained, away from some goals and consequences, yet towards others.

513. Performativity is a concept of activity related to inscribing and scripts, but done through words as processes that call situations into being, as in a theatrically 'staged' performance. Judith Butler (1990) and Eve Kosofsky Sedgwick (1990), follow Austin (1962) in developing an increasingly more pervasive and less formally 'staged' understanding of performativity. In effect the 'staging' becomes insidiously 'behind' every foregrounded utterance. Cindy Patton and Michael Brown have been developing performativity in their approaches to queer theory. They show durable aspects of geographical and textual and organisational materialities. In so doing they destabilise understandings of 'identity' being essential or inherent, while also destabilising 'stages' by introducing a hybrid tension between the places and the spaces that interact in the producing of a 'stage effect'. Brown's (1997) usage of hybridity is an area that might well be connected to my usage in this NEP research.

limited or unsustainable, partly because their illegality ruled out a commercial infrastructure. Nevertheless, the reason for needing exchanges is that illegal markets in drugs and legal markets in meeting health demands are both characteristic of modern societies.⁵¹⁴ An entanglement of crime and health markets is therefore only to be expected.

514. Since 'enterprise entrepreneurs' respond to the profit incentives created through prohibition by supplying a universal human desire for enhanced performance through appropriately modern social and material technologies.

Section 4

Hybrid Relations

Between policy and programme: The case for a hybrid NEP

Good rulership is equivalent to mildness... If the ruler uses force and is ready to mete out punishment and eager to expose the faults of people... (his subjects) become fearful and depressed and seek to protect themselves against him through lies, ruses, and deceit... If the ruler continues to keep a forceful grip on his subjects, group feeling will be destroyed. If the ruler is mild and overlooks the bad sides of his subjects, they will trust him and take refuge with him... Everything is then in order in the state.
(*Kitab al Ibar*. ibn Khaldun, (1380): 153)

In the previous chapter I described how the niche environment of the NEP's configuration of representation and administration developed alongside a commercialising of its infrastructure. I related the NEP's commercial control over syringes to a long-standing uncertainty over the regional infrastructure, policy negotiations, and representational ethos of the peer groups. I analysed how patterns of surveillance and trust became embodied through infrastructural specialisation, as an intensification of conflicts over NEP policy, while exhibiting a situational ethics relevant to wider aspects of harm reduction. I showed how antagonisms over NEP policy and practice intensified into overt conflict between officials and peers, despite their prior and later alliances. I showed how a peer-professional character and identity has been described through such situations, as well as helping to understand those situations.

My even earlier chapters of stage-by-stage social history analysis prepared the ground for the more structural-interactional analyses that have led into the current chapter. The historical and structural articulations are complementary. Both are needed for analysing the case since where the NEP participants recorded their immediate problems and options these were understood as much topologically as narratively, but not as sequences of stages, or cycles.

In this chapter I partially pull back from tight details to discuss wider patterns of understandings, constraints, and motivations. These wider aspects articulate the external environment, boundaries, and internal cohesion of the NEP as a whole and coherent case.

This chapter proceeds in four stages. The first section establishes the continuing relevance and articulation of my argument relative to the preceding and following chapters. In the next section I argue that the public and private capabilities of the NEP infrastructure have and continue to be hybrid in terms of 'structural agency'. The third section continues these arguments by linking the NEP policy goals to the gaps in implementation caused by the policies of hiring peer 'experts in IDU-ology' to provide a specialist linkage between the governing and governance of illicit private conduct. The final section partially integrates the complexity of agency, structure, and policy into an argument for a whole, hybridly-articulated, NEP case.

1 Reorientation: Progress through structural antagonisms and alliances

In 2005, an amendment to the *Misuse of Drugs Act* shifted the onus of proof onto the police for charges of possessing syringes. Previously, if anyone so charged wished to use the defence created by the needle and syringe legislation and regulations, they needed to establish to the Court's satisfaction that they had purchased that syringe from a legitimate NEP outlet. After the 2005 amendments, it was the police were required to prove that such syringes had not come from a legitimate NEP outlet. In theory this removed a troublesome gap in the legal codes. This gap should no longer have contributed to the shaping of the NEP, but the practical reality has been different, since the arrests for possessing syringes have continued.

The 2005 amendments to the *Misuse of Drugs Act* reinforced two sections under which people could be charged with possession of drug-using paraphernalia, such as pipes for smoking marijuana and amphetamine products. Section 1(a) was aimed at criminalising the technologies and the property of drug users, but excluded syringes. Section 1(aa) distinguished licit from illicit syringes. This sub-section protected the NEP by legitimising its monopoly over supplying syringes outside of medically approved usage. Yet in 2007, people have been charged with the possession of syringes, not under section 1(aa), which had been aimed at protecting the needle exchange, but instead under section 1(a), in breach of the letter and spirit of the *Misuse of Drugs Act*. A judge might accept a technical defence argument for striking out the syringe possession part of such charges. Yet making this argument would require a degree of legal expertise, expense, and effort not usually exerted by arrested IDU.

The situation is complicated further by syringes being used at times for measuring liquids, and so being defined as 'paraphernalia' if used for preparing drugs. A charge under section 1(a) might seem warranted to a Court if only those substances that were primarily smoked or taken orally but not injected had been found alongside syringes. It would be no defence to claim that such drugs, for instance amphetamines, were intended for injection, since that would be admitting to a charge of intending to administer an illicit substance, for which no defence is provided in the needle exchange legislation. The scale of this problem is indicated by the Mental Health Survey of the non-institutionalised New Zealand population in 2006 (Ministry of Health, 2006f). This survey showed that over 90% of those using illicit substances also used cannabis (Wells & McGee, 2007). A syringe can be used to pressurise cannabis with solvents to produce a concentrated extract, (pers. obs. 2005) similar to how espresso coffee is made. A search of most IDU domiciles would find cannabis and smoking implements as well as syringes, leading to potential syringe possession charges, to the undercutting of the rates of returning syringes, and to distrust by IDU in the safer-using intent of the legislative frameworks that penalised safer-using practices.

By following the ways in which syringes are active and influence particular incidents it is seen that syringes are not constrained to being a single use technology, with but a single social meaning. Their use overlaps between injecting into bodies, measuring liquids, and moving liquids into narrow neck containers. Such uses are technologically normal, but become morally abnormal and prohibited when the substances used are illicit. When observed, such substances instantly convert the syringe from licit to illicit. In this conversion, the messages borne by such syringes shift from their capabilities for industrial and health use, to their crime related capabilities.

These problems show that the semi-legalisation of the possession of syringes does not adequately explain the durability, changes, capabilities, and significance of the NEP. Syringes have remained both illicit and defensible in Court, depending on circumstances that include the presence of other 'meaningful objects' such as cannabis, and include the character of the arresting officer. The turning point of a law change in 1987, followed by another in 2004, does not explain how and why some police continue to undermine the trust of IDU and the health goals of the NEP. Nor does the event of the NEP becoming organised around the commercially competent supply of syringes explain the prior expression of peer-professional logics in the patterns of gay community organising after 1983. However, the law changes do help to identify gaps between the codes and the practices involved in moving used syringes from private situations of harm, to professional disposal, in the pursuit of public health.

The difficulties experienced by the NEP in ensuring the return of all syringes draws attention from the well-organised NEP infrastructure to the less-organised life-worlds of IDU. In this messier world, crime and health systems have been institutionalised through the activity of objects within a cultural framework of the understandings of participants. IDU and police are antagonists, appearing as intelligent objects to each other. Their structural antagonism demonstrates the continuing need for the NEP to mediate a working articulation between IDU and the profession of policing. Such an articulation involves forceful antagonisms, as expressed in the following form letter from peer-professionals to support IDU charged with possessing syringes:

We consider that charges brought under the Misuse of Drugs Act of possessing needles and syringes and other injection equipment go against the intent of these regulations, are malicious and erode the principles of the Needle and Syringe Exchange Programme, the New Zealand National Drug Policy and crucial public health objectives. (NENZFlash, 2006: 8)

These arrests illustrate the difficulties experienced by a peer-profession when attempting to alter the self-centred motivations and practices of both police and IDU. Police defend their institutional territory, including their rights to harass and to exclude competition, while IDU generally aim to stay out of sight and out of prison. Prohibited objects, such as drugs and paraphernalia, including syringes, have constituted a key connector between IDU and police. These objects motivate both personal and professional activities. IDU may illicitly obtain money to buy drugs, which they

locate by following their information network. Police follow their surveillance data on IDU associations, and observe incriminating objects, which are used to justify ‘following’ activities such as search warrants and arrests. Illicit objects such as drugs, and at times syringes, are both motivational and informational, attracting surveillance through the range of information systems involved in governance.

The shifts in syringes I have described have been accompanied by a shift in NENZ policy as regards the police and the Ministry of Health. Following the strike threat in 2001, NENZ was attempting to regain the confidence of Ministry officials, just at the time when the police reneged on their prior commitment to support a Bill decriminalising all syringes (Henderson, 2007. pers. com.). Despite HCV incidence and other gaps in coverage remaining as significant problems, NENZ has increasingly relied on the goodwill of the Ministry, partly to counter an increased willingness by police to undercut the public health goals of the NEP. Ministry support has been encouraged by the peer-groups adopting new point-of-sale monitoring and data-integrating systems, facilitated by NENZ. These systems have reinforced the pattern of the peer groups providing more accurate and relevant information, for instance about the numbers of IDU charged with syringe possession, than has been available from the police.⁵¹⁵ In these shifts, the combination of temporal eventfulness and structural effects produced from strategic boundary work have been re-expressed as a core pattern of the NEP’s hybrid capabilities.

This situation illustrates how events are, of necessity, continually made into sense by the individual and collective participants. Institutionalised motivations emerge alongside the non-human life and material possibilities which differentiate and complexify our accidents and purposes. In chapters 4 to 9 the history of syringes and syringe-users has been traced in terms of events, where iterative overlapping cycles, turning points, path-dependencies, and trajectories have outlined the shapes of how changes did or did not occur. Yet to understand such changes, and to evaluate the capabilities for future change, it is necessary to also trace the interface of effects. Events and effects combine to explain how, and from what forces, things changed. The following discussion co-ordinates material from the areas that strongly influenced the NEP, in order to explicate the NEP’s character and its articulation of hybridity.

2 Structure, agency and hybridity

Since 1988, the NEP has maintained an almost zero level of HIV transmission via injecting drug use. The NEP has improved public access to health information about HCV and reduced other hazards from unsafe injecting, such as bacterial blood infections. Sterile syringes have been

515. Henderson (2007, pers. com.), Blacklock (2003, pers. com.). See Blacklock (1998). See Appendix 3.

provided and used syringes recovered, thereby improving the safety of private and public environments. Yet the NEP has achieved this public health goal in a seemingly counter-intuitive way, not primarily through overt media or other public campaigns. Instead the NEP has prioritised the material objects, domestic sites, and the shared meanings private to IDU while distancing these sites of illicit activity from public attention.

This shifting of the NEP's emphases between public health and private deviance has problematised the conventional understandings of structure and agency found in the maintaining of the boundaries between the public and private realms. Both public and private structures are observed in the codes and expectations that shape institutional boundaries. Public and private agencies appear in the motivations that propel the movements of objects and histories. Yet the nodes and webs of IDU interactivity have been excluded from public spaces and legitimate status. The analyses I have cited in chapters 2 and 3 that outline the outlawing of self-injecting practices and drugs in the early twentieth century have not been contested in published peer reviews. However, there is also little academic interest in this field, or in the funding of new research projects. This normalisation of exclusion from public agency has produced the private markets and social networks of drug circulations, which have shaped the movements of syringes. Despite this non-contentious appearance, analytical and policy attention is challenged by the hybrid aspects of structure and agency.

The institutional codes and infrastructure of the NEP environment were not the only cause of its developments, despite influencing the activity of the human and non-human participants in ways which constrained and empowered the later shapes of the NEP. The significance of human agency is illustrated by the way the illicit peer-professional syringe suppliers, such as Mr. Pollard's pharmacy in Christchurch, first piloted, then implicitly challenged, and then facilitated the official programme, as described in chapters 6 and 8. Although Mr. Pollard was strategically well-positioned to select among a number of tactical responses to the perceived needs of his customers and better public health, so also were many other pharmacists who chose differently. Mr Pollard, and a few like him, were exceptional amongst their colleagues. We have seen how Rodger Wright and Gary McGrath established the IV League, following Bruce Burnett, who had called publicly for needle exchanges to be established.

Significant developments have followed from turning points that were influenced by such key individuals, which somewhat explains the timing of crucial events and the development of path-dependencies. These individuals did not cause events and effects to be workable, because their viability lies more in the obduracy of two blood-borne viruses, along with institutional forms and forces that allocated social resources and thereby selected for and against various possibilities. But the individuals explain why equivalent possibilities went a particular way rather than differently,

and also partially explain the timing of such events.

Individuals were important, yet these individuals were also products of earlier environments, and depended upon institutional resources for their possibilities of action. They worked mostly with rather than against institutional forces and forms. They took advantage of windows and spaces of opportunity. Where they succeeded in working against institutional forms and forces, it was through competition with their colleagues who proposed different models, or who desired to not become involved as professionals. There was, for example, no requirement for the illicit pharmacists to actually test their abilities to resist the law in a struggle where significant losses would need to be endured.

It is useful, in terms of querying public structure and private agency, to compare the differences and similarities between Wright and Kemp. Both these peer-professionals came into the area of the NEP as peers, then shifted towards professional goals and methods. Kemp had already begun to professionalise within his Methadone Clinic network when the window of opportunity for peer groups emerged in 1988. Wright and McGrath gained a degree of support from Department of Health officials, from individual medical professionals, and from individual IDU. However they could not develop a workable yet 'demure' enough model for integrating the potential antagonisms. Even if not aware of such problems and potentialities before the passage of the NEP legislation in December 1987, they became so after conflicts in the working party of key stakeholders in May 1988.

Wright was an insightful analyst of social systems, but not an effective systems operator. Nor could he expect to be well enough to manage an organisation for very long. He was a very effective communicator and motivator. He wanted people to understand the harms caused by stigma and ignorance, and to feel greater trust, which is why he dedicated his last years to visiting schools and talking directly with pupils. Wright's personal commitment and life history motivated his pointed critiques of the medicalising of IDU and HIV/AIDS. I consider that Wright's direct character contributed to his failure to gain sufficient support from health professionals and Department officials to outbid Kemp's support. In terms of persona, Wright presented his concepts as an IDU who was forced into stopping drug use and becoming political due to his declining health. By contrast, Kemp presented as a healthy 'cured' ex-IDU motivated by professional health goals and associated with the Auckland Methadone Clinic. Wright worked between individuals and attempted to found a grass-roots political group. He only then presented officials with a plan for peers to be nationally employed by state health agencies. But this was not what the key officials in the Department of Health promoted. National coverage and co-ordination did not fit with the institutionalised policy for the contracting of service organisations that 'spontaneously emerged' from local communities. Such officials would have rejected a concept of NENZ for similar

rationales. This ‘spontaneous emergence’ has seemed very similar, though on a smaller scale, to later experiences of ‘manipulated emergence’ (Harrison & Wood, 1999: 758) in the United Kingdom. Harrison & Wood describe manipulated emergence as:

incentives for managers and senior professionals not only to acquiesce in the innovations, but to volunteer to participate in their development ... [they] stood themselves to gain, to contribute to the plausibility of the project’s success, and to diffuse the perception that this was the direction which others would either be compelled to follow, or would suffer deprivation for not following. ... Some of these incentives were material. Early [adopters] ... were more generously funded than strictly required. (Harrison & Wood, 1999: 758)

Other important factors were the autonomy of the new units, which meant that budget under-spending was easier to retain, and early adopters could secure higher salaries (Harrison & Wood, 1999: 758). In the case of the NEP, the salaries of the initial peer group co-ordinators were notably higher than those of later groups and managers. The co-ordinators’ relative control over funding in the founding six months caused a legacy of configurational problems within groups, and suspicions between groups. These structural problems intersected with the persona and competencies of the early peer-professionals.

In 1988, Mr Pollard’s Christchurch pharmacy model was followed by Kemp’s proposal for ADIO.⁵¹⁶ Kemp had greater experience of health systems than Wright. Kemp also expressed interest in improving methadone programmes as a separate project that usefully combined with HIV/AIDS prevention. Such characteristics, interests and goals did not scare the risk-averse officials. The interest in methadone might seem a distraction from the NEP, but it provided a strong motivator for IDU in being a potentially achievable goal, while enrolling at least some supportive addiction treatment professionals in an alliance of interests. ADIO began as somewhat different from an inherently private pharmacy practice, yet different again from the ‘straight’ political model of the IV League with its ‘straight up’ fully designed, yet already unfashionable outreach proposal.

Wright, McGrath, and Kemp all added a peer component to Baker’s alignment of pharmacists and syringe suppliers. Despite their differences, these key individuals all worked to further articulate versions of peer-professional hybridity in a form of public health that offered and required trust with IDU. They had little choice if they wanted to be effective. Once a small peer-professional change was made, later choices became easier through path-dependent processes. Yet many aspects might have been arranged differently, and if effectively peer-professional, could well have also worked. For instance, the timing of the technologies for testing, measuring and engaging with HIV and HCV have seemed highly contingent. Matters would have been very different if testing technologies had consolidated HCV as a policy actant and as an observable cultural actor before

516. Kemp was probably more familiar with several Auckland pharmacists who also sold syringes illicitly, but kept a lower public profile and did not dent the composure of officials as much as Pollard. When the health sector began to fragment with ‘reforms’, the pharmacy sub-sector angled off away from the areas Kemp has seemed more interested in, such as improving methadone programmes.

HIV/AIDS had emerged. Unknown trajectories of public risk would have been generated if HCV had preceded HIV, but such responses could not have been conditioned and channelled by the gay community in the same way as HIV/AIDS.

I have described how harm reduction aspects are 'carried' as a message by every syringe which passes over a peer exchange counter. Objects, such as syringes, have proffered their encrypted pragmatic logics, while being simultaneously active in different networks through the activity of circulating. This has permitted and encouraged the re-articulation of mechanisms and networks by a range of narrative 'translations'.⁵¹⁷ The top-down 'translations' found in official documents have supplied the frameworks of understanding for people outside the NEP. In that translation, all the NEP syringes have carried messages of consensus, partnership, and minimising harm. Yet identically branded and labelled syringes were actually different depending on their local environment and associations. Peer exchanges and level 2 pharmacies effectively supplied a higher grade harm reduction syringes, whereas level 1 pharmacies supplied a lower grade harm reduction syringe, and state agency officials arranged for the supply of harm minimisation syringes. Because these translations have been different, gaps between known hazards of disease transmission and capabilities in service delivery have been apparent in some accounts, but have not appeared in other accounts.

From a client 'translation', syringes have carried a mixed story of benefits and accountabilities, partly of returning used syringes, partly of reusing syringes, and partly of disposing of syringes privately. From a peer-professional perspective, syringes have carried messages of licit work along with uncertainties about the service quality and accountabilities to the IDU being represented. For instance, there was no specific attempt to evaluate the benefits of increasing syringe numbers, compared with increases of outreach, in terms of reducing HCV prevalence and transmission. Nor was there solid evaluation of the benefits of increasing resources for outreach, compared with lowering the financial barrier to maximising syringe numbers.

It seems necessary to focus on structural stability, since, despite the NEP being an innovation in 1987, and considered at that time to be an exception, its goal has been to create a systemic mechanism for propagating an IDU norm of safer injecting. IDU agency may accordingly be evaluated in terms of the NEP's durability and stability, together with its adaptive flexibility and enterprise. Here is seen an immediate potential for analyses drawing on processes of translation and hybridity between antagonistic goals which have nonetheless been found in a working alliance. Despite the NEP being exceptional in its founding, the rationale and justification for its beginnings are based around stable, predictable and 'normal' aspects of injecting drug use.

517. See outlines and descriptions in chapters 1, 2, and 3 and Appendix 9.4 for general usage of the term translation in actor-network studies.

The official and professional agencies that have been accountable for maintaining and improving the NEP have not found a workable replacement for its peer-professional mechanism. This is because both motivation change and the facilitation of contacts between IDU and health professionals have depended upon peer workers being trusted by the same IDU who consciously avoid dependence and monitoring by health practitioners and officials. The excluding of IDU from public agency creates collective networks of individual illicit agency, which produces social values of extreme privacy. Yet, despite the co-presence of windows of private opportunity, together with individual opportunists, any prospects of working with IDU have been associated with the emphases on public accountability and regular public practices which characterise professionalism. This hybridity between public and private, not one and not the other, not both and not neither, explains a 20 year history of avoiding drifts towards either IDU or greater professionalisation.

New Zealand health policy has been characterised as a messy reality (Martin & Salmond, 2001), which may well harbour more hybridity than generally acknowledged. However, I am studying the NEP, not the whole of the New Zealand transformations from the 1970s to 2000 and beyond.⁵¹⁸ The important point lies in the manner in which the NEP overturned the previous ‘harm prevention’ dogma that involved publicly harming IDU in their identity and chosen practices as IDU. The difference is that the NEP was created as a policy exception, despite being national in scope and pervading the drug injecting networks, whereas the Rogernomics revolution was intended to create new institutions that would turn previous policy implementation frameworks into exceptions. Notwithstanding, the NEP was strongly influenced by the conditions of possibility created by the Rogernomics revolution.

Nevertheless, the NEP did not surge, then either institutionalise or decline, in actuality or in popular representation. Instead, a cusp of innovatory activity was permanently deferred in the case of the ‘revolutionary’ NEP because of its formation as a hybrid, ‘contradictory alliance’ grounded in pragmatic needs, including a low profile and detailed focus of activity. In consequence, instead of difficulties being first defended or even celebrated as necessary costs, then later denounced as an unwarranted, indecent public effort and sacrifice, a plateau of (semi-)permanent difficult activity emerged within a small locale, hidden from the general public.⁵¹⁹ Within an invisible pocket we find a plateau of possibilities and significance for health work that simultaneously follows and crosses boundaries of stigma and deviance. The plateau emerges from the manner in which the refolding of institutional boundaries has been a condition and vehicle of the following and crossing

518. For discussion of revolution in terms of New Zealand’s version of international neo-liberal changes see Easton (1999), Stiglitz (1999), Russell (1996), James (1986).

519. Some case study approaches would go beyond such a restricted locale, and seek in a Deleuzian mode to establish a whole, favouring or distinguishing between perhaps the ‘baroque’ whole of an assemblage of unique constituents, or the ‘romantic ideal’ whole of a single unitary conceptual form of ordering. The NEP’s multiplicity became more entangled and condensed, but was not made into a unitary whole. I am less sure, however, that the NEP can be validly described as ‘baroque’ let alone a whole. Accordingly, I have stuck with assemblages, articulations, configurations, antagonisms, and mechanisms. See also Appendix 9.

processes that have characterised the NEP.

A plateau of activity might be considered static and uninteresting, of being or having been rather than innovatory, but this misses significant points. First, the means of maintaining the stability of anything durable is fascinating in an entropic reality where change is normal. Second, Deleuze & Guattari (2004) have pointed out the local nature of ‘libidinal economies’ (Massumi, 2004: xiv), whereby innovative climaxes considered normal in some locales are treated as abnormal in locales where deferral and prolongation are instead idealised and normalised. For 20 years the NEP has achieved a deferred plateau of organisational tension and problematic creativity by means of the same parsimonious, actual processes from which cusps of innovation have also emerged.

Due to the contingent factors, I doubt that any individual or agency could have simply designed the NEP as the peer-professional body it had developed into 3 years after the 1987 law change. The NEP makes perfect sense, if one disregards the gaps and ambiguous linkages, but in many ways it lifted itself by its own boot-straps past the difficulties and policy frameworks of its founding period. It did not fully create itself, but in providing a small-scale working practice with potential for extension, it certainly contributed to the shaping and stabilising of its own niche environment as a folding of institutional boundaries. It has required understanding as an eventful historical process, as well as a structural shaping, as well as an interaction of individual biographies. So might other social problems, analyses, and policy be approached.

3 Policy intentions, unintended practices, and policy gaps

I have previously described how the NEP has been characterised by shifts in infrastructural boundaries and professional territories, yet also how these shifts have been shaped by policy decisions that responded to understandings of problems and to expectations of opportunities. The NEP infrastructure was preceded by the workings of an absent-policy of ad-hoc practices whereby IDU procured syringes in illicit or informal ways, while a handful of pharmacists illicitly supplied syringes without being prosecuted. This ‘policy of practice’ was assimilated within 2 years by a shift from these grounded practices and unformed policy to a committed and formal ownership of policy at government level. The shift was carried by the changes in the control over and status of syringes, which ‘translated’ the peer-professional principles of workable responses to HIV/AIDS that had been developed in different form by trusted gay community advocates at a time when homosexuality had been illegal. Yet the ad-hoc policy patterns continued to a degree within the formal policy package that eventuated. The NEP was made highly receptive to grounded market and social mechanisms, and to mid-level policy-making by autonomous peer organisations, despite its infrastructure and the productive sustainability being centrally regulated.

New Zealand needle exchanges seem unique in the way IDU have influenced health policy by means of the delivery of health services to their peers. A mutual interplay of influences between practice and policy has been apparent. The particular, detailed aspects of policy-making and analysis have contributed to an inherent problem of integrating yet also separating the private and the public, the local and the general. Yet the hybrid activity and the conditions of possibility of the NEP situation have intensified, lasting beyond the founding generations with their institutional and tacit knowledges, thereby drawing analytical attention to this interplay. Policy patterns have offered critical insights into the capabilities of the NEP in terms of its case characteristics of external environment, internal cohesions, and boundaries where agents and actants articulated crucial differentials. The policy contexts, turning points, and conflicts explain much of the NEP development of a hybrid mechanism and its peer-professional operating principles.

Policy intentions

Although the particulars of the New Zealand AIDS Foundation (NZAF) and NEP policy were unique to New Zealand, similar general principles of the methods by which governments have organised and motivated mid-level actors have been reported in overseas studies. These principles have involved the specific formulation of codes of law and directives to the employees of state agencies. Such codes and directives were similar to conventional government processes. However, although seemingly designed to produce a similar effect and intended outcome as a government process, the measures were achieved through more diffuse and complex means. The differences involved the pattern and mass of the connections that were reshaped. The new methods of organising did not rely on a singular authority transmitting directives across a cohesive system of order-takers. Instead, stakeholders were enrolled and re-configured into a different pattern of self-surveillance, trust, and ethics. This UK shift was:

away from government through blueprint and direct service delivery dominated by public sector professionals, and towards governance through networks that bring different public, private and voluntary/community actors together to agree, plan and deliver programmes that often cross organisation boundaries. (Blackman, 2006: 109-110)⁵²⁰

This study describes an ambiguous, market-oriented, and community-focused pattern of provisional relationships between health professionals and state funding agencies. The situation described seems similar in some ways to the New Zealand health sector and the NEP developments. The UK situation supports the attention I pay to the NEP's trust relationships. One concerning aspect with governance 'partnerships' lies in their spectacular potential for abuse by better resourced stakeholders.⁵²¹ A governance style partnership may be more open to abuse than

520. See Stoker (1998), Kooiman (2003).

521. In a complex interactional issue of many factors, any interventions which primarily benefit private rather than public interests can be justified by means of a dominant coterie of stakeholders insisting that evidence is not needed, being too slow and complex to research in a situation of claimed urgency with a window of opportunity for public funding. Such abuse may be covered up by a refusal to commit funds to ongoing monitoring of the intervention, and the distribution of benefits. For instance, I have observed such a public-private 'mechanism of abuse' in so-called

previous government systems at time dominated by official interests or political elites. Blackman comments:

This is an agenda that is very much about achieving the delivery of measurable outcomes (hence the emphasis on information), but not prescribing in detail organisational arrangements on the ground. The emphasis is on working differently, and tackling joined-up problems with joined-up solutions (Cabinet Office, 1999). Local actors are given space and incentives to realise the policy intent from the centre by developing the concrete organisational arrangements locally. Harrison and Wood (1999) call this ‘manipulated emergence’ to distinguish it from the tighter policy-action regime that marked an earlier post-war era in British public policy characterised more by technocratic blueprints.

(Blackman, 2006: 110)

Blackman’s analysis is consistent with the early NEP developments. In fact a major participant, when later offering a commentary on the process, echoed official comments of the time in referring to the emergence of the peer groups from their local milieu as “contrived spontaneity” (Kemp, 2004). Nonetheless, despite reported problems with the state agency handling of information from monitoring the NEP, those early groups were remarkably successful, at least in their first years. Most survived the somewhat predictable problems of shifting from management by individual entrepreneurs to a collective Board. Yet it seems feasible that these problems would not have emerged if key stakeholders, such as several of the founding managers, had not been able to avoid scrutiny and direction by their Boards. This avoidance was a matter of policy.

The founders were allowed and encouraged by Department officials to select the members of the Boards which became their nominal employer. The internal shape of the peer groups was a foreseeable consequence of the initial NEP policy to encourage an entrepreneurial form of autonomy. The reason for promoting autonomy was to encourage services to be responsive to local particularities of injecting drug use. However, a consequence of prioritising speed as a temporal factor, over accountable relations as a structural factor, was that local particularities in the founding personnel came at times to harm the service delivery over a relatively long term, as hasty mistakes became structurally locked-in.

Unintended consequences of policy

The potential openness of governance partnerships to abusive outcomes featuring preventable

‘community revitalisation’ policies in Christchurch, New Zealand from 2002-2006. Property speculators in New Brighton allied with local government officials and politicians to ensure that a road was put through a local open pedestrian mall. The opposition from thousands of residents and visitors was disrespected and rejected by Council staff and politicians, since the opponents did not enjoy the formal access and status that had been extended to the property speculators and local business elite in the ‘consultation’ and decisionmaking process. Nonetheless, the Christchurch City Council then proceeded to ‘rewrite history’ when describing these events in later projects. The Council claimed that through two charrettes and consultation delegated to a public-private agency, it had established that the road was an initiative initiated by the community and enjoying majority community support. As of 2007, the Council had not carried out any monitoring of the outcomes of its intervention or of the opinions of residents whom it had deceitfully misrepresented in its account of events. Instead, the Council’s public-private agency, a ‘revitalisation Taskforce’ turned itself into a fully private corporate body that could legally evade legal requirements for disclosure of key documents. In this way the aspects of community health outcomes and the exclusion from public representation that characterises crime, became reconfigured in a mechanism of abuse created by local government.

harms requires analytical attention, despite the NEP illustrating useful outcomes when all of the key stakeholders have been primarily publicly motivated and only moderately interested in private agendas. The policy framework did not directly lead to a clear, well-delineated structure of accountable implementation of service delivery. Instead, the policy created a challenge over the degree of autonomy, self-scrutiny, accountability, and commitment to be found in the group processes and consequent quality of service delivery.

The peer groups met this challenge by intensifying their professional standards, first through a higher degree of internal stratification between Boards and employees, then by stratifying into a two-tier system with the formation of NENZ. The peer groups rejected the tactic of amalgamating into regional blocs in a reduction of local autonomy. Instead they restructured into a more effective and accountable form that retained an autonomous local presence within the urban-centred IDU networks. In consequence, the position of the NEP co-ordinator or manager, whose incumbent has been employed by NENZ since 1995, has benefited from the significant independence of the peer groups and thereby NENZ from direct employment or contractual pressures exerted by Ministry officials. The autonomous local embedment of the member groups strengthens the organisation as a whole against top-down capture. If the member groups feel the co-ordinator had come to represent the Ministry, or other interests considered unacceptable to local interests, they can opt-out, as the Wellington DHDP group did for several years in the late 1990s.

The logics of autonomy and representation help the NEP to retain its hybrid positioning. However, I argue that the logics of retaining their accountability to IDU also encouraged the peer groups to avoid alternative development trajectories such as regional blocs. The path-dependency of the NEP's hybridity comes from the contingencies of the initial policy framework as much as from peer-professional principles of workability, despite the later developments being initially unpredicted and most likely initially undesired by policy owners. The policy was successfully implemented through the development of the ongoing 'alliance of antagonisms', but also due to its lack of clarity, of monitoring, and of direct control, along with a measure of randomness at the highest political levels. These ambiguities and absences in structural relations created crucial incentives and opportunities for the mid-level actors to reshape their working conditions and influence policy development from the middle of the circulation of things.

The NEP was not designed as policy to protect public health, and then simply carried out in practice. Instead, it developed unexpectedly and adaptively, became productive by juxtaposing conflicting elements, while creating a protective boundary around such elements. The NEP reconfigured elements of its non-human and institutional environment, while its new form of social organisation became corporately, culturally, legally, commercially, and politically consolidated. That the consolidation has never become, nor aimed at becoming, a fully integrated system or a

modular package for replication elsewhere, is explained by the hybridity of its environment. This hybrid environment has influenced the policy and practice that first emerged as a limited response to a public threat, to then be shaped in hybrid arrangements, leading to productivity, stability, and sustainability despite limitations on resources. In consequence, within the locality and small scale of New Zealand policy and practice, although also distinctly influenced by global principles of wellness and best practice responses to HIV/AIDS, the NEP has resisted the coalescence of its antagonistic elements.

Certain IDU peers and health professionals became structurally 'bound together' as peer-professionals, yet this assemblage remained hybridly antagonistic, ambiguous, uneasy, and problematic. The assemblage we call the NEP did not become dominated by its peers, nor by professionals, nor by both in partnership, nor by the emergence of a single new coherent entity. The NEP has worked as a very successful hybrid mechanism of peer-professionalism, despite not being overtly planned as such in policy or practice. Instead, the hybridity was significantly self-organised in how it drew adaptively on the forces and forms of the existing institutional boundaries, and on the flows of the market arrangements. Because of these discontinuities and ambiguities the NEP has not been singular, nor easily managed, nor completely legal, yet has been uniquely productive of public health.

At places and times where inherent oppositions intensify into conflict, as in the strike threat by NENZ in 2001, top-down controls may be expected to be resisted at grounded and mid-levels, particularly at sites of decisionmaking that are significantly autonomous. The NEP created a niche of such sites where the things, laws, and people associated with illicit injecting activities have been conveniently repackaged in configurations and circulations that produced an acceptable though contentious degree of effectiveness and efficiency. The continuance of trust by IDU has been crucial for these sites and processes to be workable. This method has required empowering and trusting peers to work in more specialised, professional ways. Yet by also empowering the difference in perspectives of peers, by creating new expectations and autonomous standpoints, conflicts over policy directions and priorities became inevitable, as in the conventional conflicts between professionals and officials over the governance of health budgets and quality of care.⁵²²

522. Organisational growth may be expected from expansion in the size of the NEP activities and budget, increases in the numbers of sites and peer-professionals, and of those with IDU experience or HCV positive. The NEP might develop into a normal component, or appendage, of an otherwise conventional health system. Either through expansion, or through long familiarity, institutional change towards harm reduction is possible. Some change has been seen in drug treatment areas, although professional disputes over such changes continue. However, if harm reduction became completely normalised, needle exchanges and peer-professionals would not be required. The positioning of needle exchanges between exceptional and conventional provides an indicator for on-going institutional change.

Policy Gaps

Comparisons between the expectations and the actual outcomes of policy-making have been further shaped and intensified by both the designed and unintended gaps in policy and programmes. In particular, the demand for a comprehensive HCV prevention policy has drawn attention to gaps in the coverage of the NEP in practice, not only HIV/AIDS but for any blood-borne disease. Even in the cities, the pharmacy-based NEP outlets could not access and move their health materials, let alone attempt motivation work, in the prisons, schools, IDU households, or parental households. One or other of the constituents of hybridity was resisted in such sites, or the combination became too intense for the environment to sustain. This meant that non-urban IDU, those who did not trust coming to an identifiable public centre, those who did not identify as IDU because of their inexperience, those who were too young, and those with restrained capabilities of travel, were not offered services or other forms of support. Prison officers, school teachers, and parents could readily prevent information about the NEP being accessible in their premises. Some of those cared for would most likely have caught HCV from their initial injecting experiences when their vulnerability to sharing syringes was particularly high.

The NEP did not aim at universal coverage of people. It directly provided services only for the independent adults who identified as IDU. Others were left to the chances of indirect filter-down mechanisms. In this limited demographic space the hybrid mechanism I have described was sufficiently sustainable to assemble, shape and stabilise a national coverage of the urban centres. In these limited geographical places, yet also in centralised⁵²³ policy-making forums that ‘covered’ all places, IDU became represented in a legally-sheltered programme that was funded partly by the government for providing state services, while being regulated and positioned within the health sector.

I have shown in previous chapters how the gaps between criminal systems, justice systems and health systems first created a potential problem of disease transmission. These gaps then demanded interventions that could not be supplied from the justice or health systems. The gaps then became reconfigured, by means of their boundaries being altered, in an intervention to supply and recover syringes while facilitating greater control by individual IDUs over their management of injecting risks. The attempts to bridge these institutional gaps led to the initial configuration of the NEP becoming reshaped, redirected, and expanded in its connectivity due to the introduction of the peer outreach component. The peer groups, especially NENZ, have tried to further bridge such gaps by providing new forms of service delivery, yet have been consistently opposed throughout the 1990s by the same state agencies and governments which continued to permit and fund the NEP. By

523. For discussion of the way centralisation, in the UK and North America, influences spending levels, equality, cost controls, standardisation, specialisation, innovations, and diversity, see Hollingsworth & Hanneman (1989), Hollingsworth (1983: 215-220), Hage & Hollingsworth (1977).

moving from discrete practices to planned interventions the NEP has clashed with the Ministry over policy ownership. This is hardly surprising, since all health care is rationed, both by those who allocate social resources and by those who allocate their professional time and energies.

One counter-intuitive aspect is that such gaps also constitute gaps in surveillance, whereas their plugging seems comparatively cost-effective. Even more surprising is the way the seemingly most expensive gaps have been plugged first by the funding of a free one-for-one scheme in 2004, at the same time as a pilot scheme for a fairly expensive bush-net model of covering rural areas was approved for the West Coast, (as described in Section 2 of Chapter 1, and in Appendix 7). This sequence and prioritisation of funding suggests that financial considerations have been less significant than other rationales. These other rationales would include the political difficulties of intruding into the sovereign territory of the Corrections Department, and the ability of the police to formally or informally 'veto' increases in the NEP's effectiveness, either at policy level or by harassing clients for the possession of syringes. The ambiguities of this situation are noteworthy, given the number of analyses that emphasise the increasing structuring of institutions of late modernity around the practices of surveillance and the development of centres for the calculation of governance information.⁵²⁴

The formation of a single NEP system of national coverage eliminated the potential problem of pharmacists, such as Mr Pollard, undercutting the syringe prices in local areas and further embarrassing the official system. National coverage also minimised the chances of pockets of HIV developing amongst IDU in remote areas before their symptoms of AIDS became diagnosed. Furthermore, equality of access to health care has been a core principle of New Zealand health services. National coverage was considered desirable for a mix of ethical and pragmatic reasons, but these were simply assumed, and not clearly articulated in the initial planning documents between 1986 and 1988. Nevertheless, although national scope was attained from the initial stage of operations, national coverage was noticeably absent from later NEP operations. Particular sites, such as prisons and younger age groups were not covered in the initial policy framework. Furthermore, once the NEP became established, then intensified in terms of peer-professional mechanisms, the scope, scale, and coverage were not allowed to expand.

Despite holding 'national coverage' as an ideal, pointed to with pride in the official descriptions of the NEP, there were significant gaps in the earliest planning, for instance the lack of attention paid to the infrastructure and costs of collecting used syringes. As the NEP consolidated into a particular form with specific boundaries, other gaps became apparent, such as the gap between approaches to

524. For discussion of links between the generation of information and its accumulation in centres of calculation for the accomplishment of policing, see Andreas & Nadelmann (2006: 59-104, 134-249), Haggerty (2001), Garland (1999: 22-23), Sheptycki (1999), Ericson & Haggerty (1997).

HCV, as compared with HIV. Such gaps are significant because the NEP was initially designed to minimise such exclusions from coverage, yet was also driven by an overriding policy directive towards a single disease and a single preventative programme. This totalising policy directive conflicted with a network of blood-borne and other threats to health, and conflicted with the NEP's loose assemblage of multiple policy makers. Such gaps, accordingly, illustrate disjunctures in policy that caused ongoing problems, while the embedment and solidifying of such disjunctures in a national infrastructure indicates one cause of continuing problems.

One of the most telling gaps consists of the lack of financial data on the costs of the NEP. The significance here lies partly in the initial state sector environment of promoting effective record-keeping, and partly in the absence of oversight. Clearly, if the claim by the Ministry of Health that the NEP records were unavailable was in fact true,⁵²⁵ then the NEP expenditure could not have been monitored. This means that evaluation of outcomes could not have been carried out in any evidence-based, publicly accountable way. This deception of either the public and Minister of Health, or of the independent team carrying out the research, shows how the restraints on expanding the NEP services were of a political character rather than a simple circumstance. Such evidence of distrust, creating further reasons for distrusting, is of significance due to the way exchanges of trust formed the core articulation of the NEP productivity via the mechanism of peer-professionalism.

These considerations also assist in understanding the overall sector environment. The restructuring of the state sector involved the elimination of a yearly regular payment to departments that did not feature any requirement for developing the policies and holding the records needed for strategic budget forecasting. Instead, accrual accounting became enforced as a basic practice throughout the state sector. But clearly not with the NEP expenditure given that such records were not available. It is not feasible that such records were mislaid, since they would have been held in electronic as well as physical forms, and would have featured in a range of different reports, with copies. Either the NEP has demonstrated an impressive exception to the norm of accrual accounting, or for some reason, interested parties have made such records disappear with no response from those agencies to whom they have been nominally accountable.⁵²⁶

Another gap has consisted of the absence of documented protocols over the ownership and accountability for the human tissue in the returned syringes. The NEP's 'mechanism of trust' has been potentially influenced by the configurations of the private property and identification aspects of DNA, the potential for harm to IDU as a collective, the law enforcement interest in monitoring

525. and not a cover up, possibly of unauthorised projects.

526. If so, such deviance might be found elsewhere in the delivery of health or enforcement services by state agencies. For instance, the Ombudsmen's review of the management of prisons by the Department of Corrections (Office of the Ombudsmen, 2005) was scathing about the quality and quantity of many records and record-keeping systems.

traces of illicit drugs, and the epidemiological desire to monitor the threat to public health of HCV. Yet this situation seems similar to wider concerns about protections for general privacy, about the benefits of commercial productivity, and about the public health benefits of sentinel surveillance for many diseases, not just HCV and HIV. As genetic technologies become more capable, one would expect the developments of legislation and human rights protocols that focus on ‘waste’ human tissues that carry valuable genetic information about viruses and human hosts.⁵²⁷ There seems a gap between the NEP’s involvement with human tissue and the need to create policies about such material and information.

IDU had reasons to distrust more effective and efficient testing, for instance in the potential analyses of returned syringes for DNA identifiers and drugs. However, the peer-professionals agitated for 16 years for the NEP to be more effective and efficient in providing regular evaluation, health services, and representation. For these reasons, peer-professionals have co-operated with and even advocated biomedical testing, despite fears of destroying IDU trust, provided that researchers first negotiated the appropriate accesses with IDU representatives.⁵²⁸ Peer representatives effectively guaranteed, through their face-to-face reassurance, and professional capabilities, that the testing would benefit rather than harm IDU as individuals, and as collective networks or communities. But, since⁵²⁹ no protocols over such testing have ever been formalised, the degree to which peer-professional representation has empowered IDU communities has been unclear. While information of immediate value has been gained, there may also have been longer-term costs. For example, practices that do not adhere to principles of informed consent in treatment or research would undermine such principles not only in marginal areas of research, but across whole populations and regulatory systems.

A long-standing gap has involved the concentrating of NEP syringe supply and client contact into a single urban centre. This creates access barriers and inconvenience for people whose homes and drug markets are distant. The difficulties in overcoming such barriers privilege those who are mobile, urban, and adult, but penalise those who lack such social resources. These include young people in schools, older persons in prison, people in small towns, and those in rural areas. Due to such problems, a satellite exchange in Christchurch was set up in New Brighton early in 2006, in response to client requests and a survey of client needs. After 12 months the client numbers have matched the levels projected in the development plan drawn up in collaboration with the peer-professionals on the DISC Trust. This exchange has maintained a discrete, professional appearance.⁵³⁰ Another instance lies in the formation of the ‘bush-net’ syringe supply and return

527. The reasons that IDU might avoid having their DNA appropriated and on-sold would most likely overlap with the reasons that ratepayers would object to the ownership of the DNA in their body wastes transferring via the sewerage system to their local Council for on-sale off-shore or to the ESR, even if their rates reduced in consequence.

528. For participant perspectives on this issue see Kemp (1990), DIVO (1991a, 1991b, 1991c); Dickson, Austin et al. (1994); Baker (1989, 1994); Lee (1989); Baker (1988, as cited in Department of Health, 1988).

529. Attempts to further integrate this environment have been promoted at a central governance and evaluative level.

operation on the West Coast. As briefly described in Section 2 of Chapter 1, and in Appendix 7, this 'bush-net' has relied on local peer participants to operate an ad-hoc syringe supply and return network in their territory of expertise, while being supplied and supported by a mobile team based in a larger urban centre. The embedded peer is much closer to and personally following the movements of drugs, yet is locally known and trusted, while having motivational support and material resources guaranteed to a professional standard. After having been shaped, stabilised, and sustainably operated for two years, the syringes supplied in the West Coast bush-net increased from 2,000 to 20,000 per annum. These figures indicate that there had been a substantial unmet demand for this health service. This demand would have remained unmet if the NEP peer-professionals had not undertaken to provide the initial feasibility research out of their own budget, then organise several pilot programme studies, and a successful transfer of the responsibilities for funding to state health agencies (Jang & Henderson, 2007. pers. com.).

Another gap has involved the under-utilisation of peer-professionals. Although NEP peers supply outreach services in informal ways through personal contacts, their numbers have been systematically limited. The rationales for such limitations include the administrative logics of reducing risk and the financial logics of reducing costs. Neither the officials dealing with the positioning and contracts for the NEP, nor NENZ itself, have been able to provide a training programme for upskilling and increasing the resource-base of peer workers.⁵³¹ The professionalism of the peer element of the NEP has not developed to a national standard of formal training and qualification, despite the existence of informal systems for supervising and mentoring peer employees. Nevertheless, NENZ employees have contributed essential expertise to the development of standards of practice for the pharmacists involved in the NEP. In these and in other aspects of health planning, NENZ has contributed significantly to collaborations between state agencies and professional bodies. This knowledge and collegial practice has been acknowledged and integrated into the health sector in a similar way to other specialised forms of professional expertise.

According to my account, peer-professionals are only productive when actively interfacing with different sets of people and institutions, including IDU, health professions, lobby groups, policy networks, administrations, and agencies. However, NEP harm reduction services are excluded from access to schools and prisons, despite HCV infection rates remaining higher than cure rates and deaths combined. This imbalance has ensured that, unlike the extremely low prevalence of HIV, the everyday environment of IDU is 'dense' with HCV. Individuals identifying as IDU have access

530. The satellite exchange noticeably exceeds the general retail standards of presentation in the area. Despite being sited close to a school, several bars, and a party pill outlet which had attracted strong community opposition from school parents in 2005, no obvious problems have emerged between this satellite exchange and the local community.

531. Of the peer group Trust Boards, only DISC has instituted these goals in formal ways backed up by actual expenditure, and even this has been limited to on-the-job training rather than any formal qualifications.

to NEP services, but not the neophytes who are readily infected in their initial injecting experiences, and who maintain the HCV-dense environment of IDU. HCV prevention throughout the 1990s, accordingly, has not been a public health programme focused on reducing the rate of transmission in the institutional areas that create greater risk. It has instead been a policy of aggregated private health measures that focus on the individual motivation and empowerment of potential transmitters and recipients. Where individuals cannot be empowered, due to institutional constraints as in schools and prisons, gaps in health care can be expected to become barriers against the provision of trusted information about risks, against motivated peer engagement, and against access to sterile equipment.

HCV has been a 'private' disease because, after 1992, most new cases have been IDU. People with HCV are reluctant to disclose their seropositive status because of the stigma of associated IDU practices. HCV was not considered an urgent public threat, and was categorised as a private health issue, despite being endemic among IDU (NEP, 1997: 5). IDU are not a major population group. A threat to their health may have been too small to seem to qualify for public health expenditure. Yet HCV transmission has been defined as a private health issue, despite being transmitted through the practice of injection that is an IDU community norm. It seems that the criteria of public health has prioritised majority norms in a process that has excluded rather than included marginalised groups.

IDU were not considered fully part of the 'public', despite the arrangements of greater inclusion that developed around HIV/AIDS. This official attitude only began to change after economic studies in the late 1990s showed higher than expected financial costs of HCV.⁵³² Such responses to HCV indicate that the *Ottawa Charter* principles have only been applied to HIV/AIDS, not HCV, which raises further questions as to why, how, and by whom the Charter has been interpreted. From a different but related perspective, the increased funding for HCV prevention raises a question over whether HIV/AIDS would have produced an *Ottawa Charter*, or large-scale funding, or policies of seeming consensus, if the victim numbers and social profile had been low, if the disease was categorised as a private health problem, and if first world economies had not been threatened.

The gaps in coverage illustrate how the difficulties of changing IDU motivations continue to characterise the hybrid environment of the NEP. Evaluations of the NEP need to consider whether a benefit, such as harm reduction outreach to pre-IDU youth, might be too difficult, or if attempted, might be accompanied by the hazards of losing the NEP's hybrid sustainability. This aspect is seen in the way the HCV Support Group in Christchurch has accomplished forms of access and education in schools which the DISC Trust it emerged and separated from could not provide. Because the HCV Support Group has been disease-centred on health care, rather than syringe-centred on prevention in a hybrid crime-health mechanism, the HCV Support Group can more

532. See Sheerin, Green & Sellman (2003, 2001), Easton (2002), Nesdale et al. (2000).

readily access schools and non-IDU. In situations where maintaining the trust of parents and school boards is necessary for access to youth, the HCV Support Group exercises a more sustainable type of hybridity than the NEP, because it does not so directly represent IDU or syringes.

The NEP harm reduction policy succeeded in minimising HIV prevalence among IDU. However, it is significant that HCV control was not achieved, nor attempted, despite a similar route of shared syringes. HIV/AIDS was seen as a threat to public order, as well as to health, whereas HCV only seemed to threaten a marginalised group. The differences between HIV and HCV illustrate a sorting process, involving health professionals and health officials and politicians, that leads to some groups being marginalised and others not. The different ways risk may be understood and presented as a public norm is clearly involved in this sorting process. Such differences and difficulties contribute to explanations for a range of employment problems and gaps in service coverage, such as the vulnerability of young IDU experimenters to HCV transmission.

Understanding the capabilities of the NEP requires understanding how initial gaps in public health arose from an interplay of ecological contingencies, institutionalised practices, and policy goals, yet how closing these gaps ‘locked-in’ gaps in the public health coverage of ‘private’ stigmatised populations.

4 Can the NEP case be integrated?

In this section I partially integrate some distinctive aspects of the NEP developments to better delineate its character as a case that features characteristically transgressive boundaries and hybrid activity. This account has shifted in its focus from a changing environment of viral, legislative, and institutional constituents, to the configuration of a quasi-criminal quasi-profession, then to the outcomes in practice of NEP policy and gaps. The NEP began with a relatively forceful though somewhat ambiguous policy directive. However, when attempting to carry out this directive, a pragmatic, grounded ethic of policy-making emerged from the interplay between the difficulties of environment and occupation.

The ethos of the NEP is ‘to neither condemn nor condone injection of illicit drugs’. Nonetheless, this is a given code of behaviour, or normative moral, not an ethic, since it does not indicate why such conduct is desirable by directly specifying desired outcomes. As I describe and argue in chapter 9, the ethic of the NEP is that those injecting illicit drugs should be given solid evidence-based reasons to trust, rather than distrust, health expertise in order to empower forms of self and community care. By identifying this ethic, which reframes the morals and codes that cause the problem of transmission of blood-borne diseases, my analysis necessarily transgresses those boundaries of the NEP that I have also described as solid. This echoes how the productivity of the

NEP developments, seen in the shifting of forms into new arrangements, has delineated yet also destabilised an interactive heterogeneous environment by developing as a single, autopoietically shaped case.⁵³³

I have described in previous chapters how the NEP peer-professionals acquired a hybrid competency in providing sterile injecting equipment of professional quality and disposing of returned syringes, while motivating IDU to attain greater control over injecting risks. In the exercise of these competencies, these peer-professionals provided public representation on behalf of IDU, while mediating aspects of the surveillance over IDU. Over this period injectable drugs became more criminalised. Nevertheless, IDU, as peers and via peers, became less excluded from 'the public', resulting in an increase in their self-governance of health, in contrast to the general repression of IDU as criminals by intent. This increase in the self-governance of IDU accompanied a shift in the unique capabilities of the NEP. During the 1990s the NEP moved from a stand-alone, experimental exceptionalism towards an uneasy integration. The integration was first towards the regulatory system of the national health infrastructure. But this integration then shifted towards a greater influence and control by the justice sector, as seen in the police in 2004 shifting from supporting to opposing the decriminalisation of syringes.

These movements have been uneasy for several reasons. One has been the large-scale unpredictability of the sectoral changes towards a 'whole of government'⁵³⁴ interagency environment, despite evidence of 'silo-isation' practices and attitudes (Ministry of Health, 2006d), and with regard to privacy protocols (New Zealand Government, 1994b). Another has been the inherent hybridity of the NEP. The third, however, has been the ambiguity between crime and health institutional boundaries from which the NEP has drawn its necessity, forms, and force. The NEP was founded on a seemingly essential institutional difference that constituted such a boundary, yet the forms and interactivities of the NEP critiqued and weakened the rationale for such institutional boundaries. Such uneasiness is observed as the NEP moved from management by a Taskforce dedicated to HIV/AIDS, then to inclusion within the funding frameworks of the mental health policy and belated policy over HCV, yet described from 1998 to 2007 as a component of the National Drug Policy (Ministry of Health, 2007: 17).

Along this uneasy way, the local practices and community norms of IDU also changed. IDU networks moved somewhat towards greater contact and participation in nation-wide systems of

533. See Mingers (1994), Luhmann (1986b), Hejl (1984), Varela (1981a, b), Varela, Maturana, & Uribe (1974) for a range of applications of concepts of autopoiesis. The term generally refers to self-organisation. More specific aspects include a dynamic, non-equilibrium involving forms and forces in functional states. As I use the concept of autopoiesis, these states shape and stabilise various flows from a wider environment through the forms and processes of an autopoietic situation, or focus, or entity, or mechanism. The dynamic control of such flows creates the conditions of relative stability. Autopoiesis is an attempt to describe the core and boundary working of life processes in more general, systemic terms which can overlap and engage with non-living technological processes. See also Walley (1991), Prigogine & Stengers (1984) for related work on ways of analysing complexity and order.

534. See Ministry of Health (2006), State Services Commission (2001), IACD (1998).

health-promotion and self-monitoring. Nonetheless, this change was insufficient to significantly decrease the hazards of blood-borne HCV transmission to the public, particularly to youth and future prison inmates. I have described how policies were conceptually developed, then implemented, then adapted in practice through cycles of infrastructural developments, leading eventually to conflicts over policy with the Ministry of Health. The NEP's engagement with such difficulties offers an evaluation of capability. For example, the NEP managed to survive with a strong peer component, whereas some other AIDS service organisations in New Zealand and overseas have not. Nor is every health service agency been willing and capable of biting policy chunks from the official hand that feeds it. These eventful comparisons of capability, combined with the effects of peer-professionalism, address my research question on how the capabilities of the NEP might be best understood.

The ability to overcome historical obstacles of founding, then of constraints to expansion in some areas, has been facilitated by committed personnel. But more to the point has been the way in which the peer-professional resources, experiences, and goals of these people interacted with a peer-professional institutional niche. This semi-structured, hybrid indeterminacy facilitated resilience, flexibility, and adaptation. By surviving for long enough, time was made for systems of more effective management to develop, which in turn enabled more regular collaboration with epidemiological and public health researchers. None of this has been a natural development that could be simply 'relaxed into'.

I have argued that the NEP has developed by means of a unique hybrid mechanism of peer-professionalism which, together with contingent factors, has produced a 'forceful' capability for protecting public health through an organised application of harm reduction logics. This protection applied across wide areas of New Zealand society, during the same period that comparable programmes developed overseas. By 'forceful' I emphasise how the capability of the NEP has not only responded to motivations from its 'external' environment, but has also produced its own force of 'internal' self-organisation and influence over the organising of its environment. This is the type of force generally associated with professions, rather than mass pressure groups, because it is founded upon expertise and experience that is always in short supply, not just when labour is withdrawn in industrial disputes. Such hybrid professionalism has been observed to constitute a significant aspect of the networks of agencies and accountabilities wherein the governance of health care has contributed to the effect of statehood.

I further argue that the NEP has developed as a way of doing state policy by other means. I touch here on the process of following the assemblage of policy from political and planning needs. These needs are very different since politics is inherently contingent, whereas planning involves a crusade against contingencies. In this fog of planning, markets and policy seem both a form of living

activity and a form of undead movement. It has been seen in the NEP history that policy is an effect as much as a cause, and an event as much as a dated announcement. This seems significant when personalised health interventions by professionals, after the harm emerges to be diagnosed, is becoming supplemented, if not replaced, by population-based wellness systems of deferring harms through the agency of officialdom. Yet whereas health professionals have historically enjoyed great trust and reasonable compliance from a patient public, official systems have been generally disparaged, being understood as constraining rather than enabling personal projects and desires. This is where the crime or deviance of desires intersects with health systems in ways that, although less intense than the NEP and peer-professional arrangements, can nevertheless be usefully informed by the historical events and institutional effects in which the NEP has manoeuvred.

The NEP only worked as a mechanism because diverging aspects were maintained in alignment. These aspects could not be rigidly aligned because they had been assembled from different arrangements with opposed or different logics. Until such arrangements became adjusted, the alignment depended upon local work that ignored conflicting logics and goals while connecting seemingly unfitting elements. IDU and their logics needed to be held separate from opposing occupations and logics, or reframed in a new category formed by rearranging boundary lines. 'Harm reduction' effectively separated IDU from the law enforcement of harm prevention logics, while 'harm minimisation' incorporated both, at a high level of funding, of regulatory permissions, and of abstraction. This interactivity, on a small scale, produced uncertainty. Furthermore, the NEP environment was uncertain since many of its constituents worked at evading surveillance. Working arrangements were inherently difficult and ambiguous because the goals and environment featured a multiple, partial, and divergent connectivity.

The NEP is costing more because it is achieving more. The NEP had been underfunded and prevented from achieving its designed goals of national coverage. As these gaps were slowly closed, the costs increased. A new blood borne disease then appeared and became increasingly a public problem. Then a new government with different spending priorities appeared in late 1999. A review then increased the public status of the programme. The evidence base allows the cost increases to be justified, unlike in some areas of mental health and many areas of addiction treatment. As the number and percentage of IDU increase, governments wish to have instruments to measure and monitor such changes, with the NEP having proven itself to be an extremely precise and sensitive instrument.

The increasing costs of the NEP also derive from the pattern of peer-professionalism. The work of articulating the antagonisms of this hybrid pattern has required continual resourcing, partly from government funding. As either the goals increase in scope, or the activities extend in scale, or the difficulties otherwise increase, more resources, including funding will be required.

In the following chapter I close my argument on hybridity by showing how the principle of peer-professionalism acts as the single most significant characteristic of the New Zealand NEP, rather than merely being an emergent aspect of the programme. I argue that not only the ‘being’ but also the ‘becoming’ of the NEP was locally emergent and generalised. My analysis uses two complementary perspectives and methods. First, I consolidate the grounded case of the NEP. Second, I problematise the consolidation with the peer-professional resistance to closure. This argument not only explicates the NEP’s complex partiality and multiplicity, but also how it may be approached as a singular quasi-object effect, or quasi-case.⁵³⁵

535. Here I use a case approach to merge postmodern attention to relationality and ambiguity with a pre and non-modern attention to things, by using a topological type of sociological imagination to shape and condense empirical details while constraining the abstract rationality which is required to connect and draw significance from such details.

Between practice, pattern, and principle: The case for peer-professionals

What replaces the one big mind-independent world about which scientists were once said to discover the truth is the variety of niches within which the practitioners of these various specialties practice their trade. Those niches, which both create and are created by the conceptual and instrumental tools with which their inhabitants practice upon them, are as solid, real, resistant to arbitrary change as the external world was once said to be. But, unlike the so-called external world, they are not independent of mind and culture, and they do not sum to a single coherent whole ...
(*The Road Since Structure*. Thomas Kuhn, 2000: 120)

In the previous chapter I stepped back from the grounded detail of the NEP history by focusing on effects more than events. I did this by pulling together the more significant themes, or patterns, from which that history has been interwoven. The articulated connections of these strands encouraged a more structural analysis, within which abstractive methods were utilised and controlled by the application of sociological imagination, where: "neither the life of an individual nor the history of a society can be understood without understanding both" (Mills, 1959: 3). I emphasised the hybrid pattern observed in the articulations of infrastructural goals, problems, and capabilities. However, I presented the articulation of such historical and hybrid logics, along with the organising of that infrastructure, as co-evolving. I drew attention to the unexpected outcomes of the NEP's policy initiative, together with its ongoing trials of control between different levels and sites, but did not develop the boundaries of policy analysis beyond that applicable to the whole of the case.

In the current chapter I continue the emphasis on hybridity by closing my argument for the hybrid capabilities of the NEP being best understood as 'the emergence of peer-professionalism'. By peer-professionalising I mean an active and evolving way of provisionally 'locking-together' strong and continuing antagonisms between crime and health within a complex, partly indeterminate environment featuring key interactions between elements of institutional assumptions and expectation.⁵³⁶ I pay as much attention to the processes of emergence, influenced by gay community organising, as I do to the later form in which the peer-professionalising has stabilised. I emphasise how the active working of peer-professional motivational logics has interacted with practices of shaping, stabilising, and sustaining.

I have presented an account of the messy whole of the NEP as including the peer-professional actualities and logics as understood by participants. However, this current chapter presents an account of where crucial: "empirically confirmed and logically consistent statements of regularities" (Merton, 1973: 270)⁵³⁷ join in a way that explains the motivations of participants. The

536. By a 'pattern of peer-professionalism' I do not refer to a deterministic cause that acts as a foundation for a superstructure of hybrid indeterminacy. The causality is far more complex and ambiguous. See Law (2004: 41-43), Watson-Verran & Turnbull (1995: 117), Deleuze & Parnet (1987, v111). See chapters 2, 3, & 4.

537. While appropriating Merton's prescription for good science, of 'natural' and 'social' types, I nevertheless find his

hybrid division of my narrative argument leads to a folding together of the two methods, these being the acute focus on case aspects together with the wider awareness of practices and principles, into a whole pattern of peer-professionalism. But here I should specify what I mean by ‘principle’.

A principle is generally understood as a pattern, or abstract object, but also a likelihood of more general applicability and a guide to activity, including the activity of understanding. Principles, accordingly, extend the caseness of cases by resisting any total closure in the process of encasement. As an analogy with windows (casements), the fold, or hinge, argues by means of its design against the intention, purpose and actuality of permanent closure. So also does a latch. The impermanence of opening and closing is equivalent to the actuality of alternation, or iteration. A window of the casement mechanism, like a case, is inherently in the middle of things, between open and shut, inside and outside, barrier and portal.

I have chosen to close the case argument with peer-professional emergence, as both a process and a pattern, or principle, not with the wider, more easily delineated, but more empirically located case of the NEP. A cautious reason is that by unduly totalising or locking-down the case I would be undercutting my own argument for hybridity. My chain of evidence and logics depends upon the problematisation by means of analytical opening up, and going no further than the evidence allows to be opened up, rather than privileging the closure of case boundaries. A more directly engaged reason is that to be convincing, my argument needs to become topologically translated into a concept, expressed as a more compact, categorical quasi-object. This quasi-object needs to express greater closure and compact portability, yet without making unevidenced claims redolent of universal truth-hood, and so is a more useful and appropriate way to close my NEP case and my case for this thesis.

I develop this argument in 4 sections. I first use the most compelling NEP case material to outline my key claim that peer-professionalism exists both inside and outside the hybridity of the NEP case. From this grounded foundation, I outline the contexts of peer-professionalism in the institutional conflicts, wider than the NEP, between IDU and health authorities over the territory of drug use, self-medication, and self-injection. I then describe the crucial articulation of peer-professionalism which preceded and became shaped by the later NEP. In closing, I present the key reasons why the relationship between my source material, methods, and emergent concepts are persuasive.

recommended methods to be positively counterproductive. Instead I present consistent, regular accounts by means of the disjunctures and inconsistencies of ‘messy realities’. See chapters 2, 3, & 4.

1 Shaping the argument

My analytical description of the organising of the NEP has utilised an interplay between assemblaging and mechanism. According to concepts of ‘assemblaging’, which involves putting things together when needed, influenced by selection constraints but not by any predetermined structural plan, IDU peers were put into a site together with needs and models for professional practices. Yet an equally valid perspective is that the peers and sites were drawn into becoming actual in the same processes as they were drawn together. Furthermore, other possible shapes and turning-points were selected against and became correspondingly more difficult, which partially explains why such possibilities did not eventuate. As well as being descriptive, the pattern of peer-professionalism has also been active in the way it has put, drawn, and selected for what works, or does not work, in the occupation and niche sites of NEP interactivity.

Peer-professional activity has permeated and shaped the NEP yet did not merely emerge and solidify from the NEP, since it was active in the two years of illicit syringe supply that preceded and provoked the NEP. The preceding gay community organising did not involve syringes yet also was strongly peer-professional in the way crime, stigma, secrecy, and distrust of health professionals came to be re-articulated. In part, peer-professionalism produced the NEP by actively problematising the environment where syringes circulated. Nevertheless, the participants in the NEP have maintained and reacted to this institutionalisation as they experienced its urgent demands of the moment, and as they felt it should work in achieving directly stated goals. These participants placed no significant emphasis on any categorisation of a peer-professional logic that permeated a grounded NEP reality.⁵³⁸ The peer-professional pattern I describe has provoked and informed active agency and moral understandings within its articulation of productive antagonisms and ambiguity, but has not been reflective or previously abstracted in the specific way as articulated by myself in this thesis.

I describe such peer-professionalism as an unforeseen consequence of urgent policy responses to the contingency of HIV/AIDS, combined with the institutionalised minimisation of the equality of IDU as citizens. However, such temporal turning-points in policy and the structural reshaping of institutional boundaries make little sense without simultaneously understanding the contexts, activities, agencies, objects, and motivations of the actual peer-professionals themselves.

The NEP’s development has not been constrained to only the formal NEP, nor only syringe work, nor only IDU and stakeholder agency. Various types of agency have been observed to emerge from the NEP’s network environment, including distributed and network agency, along with the co-agency of technologies and non-human viruses, as well as individual human agency. I have pointed

538. This seems a way of occupational solidifying, of drawing positive aspects towards a surface of everyday work and meaningfulness, and thus solidifying that surface into an overt mechanism of circulations, yet also being a system that includes the invert and fluid aspects other than on the surface.

out how humans have assisted viruses such as HIV and HCV to feed on other humans and utilise humans for viral reproduction. Humans have assisted such viruses by constructing technologies such as syringes and by criminalising injecting drug use. It may be that some viruses are evolving into dependence on human technologies. By creating the NEP, humans have not only added to their control over viral co-evolution, but have created a social organism that expresses agency, in the sense of modifying its infrastructural and institutional environment in a quasi-rational, self-maintaining way.

It does not matter, from this perspective, that no single embodied individual human has carried all of this agency, provided that its crucial forms, motivational forces, and constitutive articulations can be identified. This agency has been observed and analytically identified to have been active in a tight cluster of practices and logics. These activities led from the gay organising and criminal syringe supply in 1985, to the founding of the NEP in 1988, to the deviance of the threatened strike in 2001, and to the continuing arrests of IDU for syringe possession. Such arrests, which undercut the trust relationships of the NEP, illustrate how the alliance of stakeholders involves continuing antagonisms that resist a fixed resolution. The ambiguity of peer-professional activity derives partly from such distributed, antagonistic agency.

I suggest that the pattern of peer-professionalism I describe constitutes an ordering principle that characterises the NEP environment, rather than merely being a feature of that environment. This character invests the NEP with a motivational force towards the self-maintenance of its infrastructure and logics. Part of this force derives from the external influences of requirements evinced by publics, institutions, and politicians, as described in the overall social history in previous chapters. However, before these requirements became formalised in a policy and programme, such requirements have been seen in the criminal forms of local responses to HIV/AIDS. During the course of the social history of the NEP, an internal influence has consolidated in the shape and interests of the new occupation of peer-professionals. These people, embedded in their working practices of health care, have embodied wider interests, furthered their own careers, and represented the publicly voiceless IDU. Peer-professionalism has been articulated through external and internal drives that in conjunction shaped and stabilised the configurations of the NEP's occupational infrastructure, providing greater sustainability despite continuing crises. Both external and internal influences combined, through strong logics but not easily and not necessarily, to explain the overall durability and other capabilities of the NEP.

My argument relates many specific details of the social history of the NEP to a single, more abstract pattern of peer-professionalism. I present reasons for this pattern being the most explanatory, pervasive, and useful of the hybridities that support the NEP. These reasons draw on the previous analysis of the NEP's general hybridity, within a generally heterogeneous

environment. However I argue that the multi-stranded complexities of the NEP's hybridity and heterogeneity can be braided⁵³⁹ into a singular concept which can function as a 'handle' to the otherwise distracting multiplicities and ambiguities.

2 Contexts of antagonisms and boundaries

In New Zealand, commonly injected drugs, such as methadone, morphine and ritalin (Brunton & Henderson, 2005) have often been diverted from the authorised systems of medical professionals. These drugs have then been injected using the tools and techniques conventionally considered to be medical in their hazards and required skills of use. Such connections draw attention to the ways in which the criminalising of drug use, especially self-injection, has increased the professional autonomy and authority of health specialists. Professional interests have been strengthened by religious and government reliance on biomedical or psychological expertise to define the social risks of different drugs in practice and in theory. Professional interests were strengthened by gaining legal support from governments and moral support from religions for prohibiting lay use by medically appropriating recreational substances along with their associated desires and desiring identities. Leaving aside the rationales of professionals for such endeavours, one can draw attention to the seizure by health professions, particularly medicine and psychiatry,⁵⁴⁰ of the means and right to define normality. Where normality goes, there also goes morality. The legal monopoly over substances and related technologies links such professional interests to the goals of state officials, and the projects of governance.⁵⁴¹

IDU interactions include such institutional backgrounds because internal physiology has, for over a century, been a medical domain, forbidden to competing professions. This domain has also been forbidden to lay desires for intense experiences and autonomy over the biochemical constituents of consciousness. IDU may not necessarily understand injection in such terms. Nevertheless, the

539. Since a matrix may be read across, vertically and diagonally simultaneously, a matrix is closer to the simultaneous workings of different processes across distances with no clear connections, that characterises a 'messy reality'. One can designate a matrix that includes the strands and themes of the NEP, and which does not force such simultaneous happenings into a linear narrative. To adequately understand the simultaneous complexity of the NEP, a matrix mode of understanding seems required, as I have discussed in chapters 2, 3, and 4. By connecting to every point on the matrix, the concept of peer-professionalism enables the simultaneous complexity of the NEP to be translocated and translated without deep synchronic study of its components.

540. Certain types of psychology, particularly evolutionary psychology, seem permeated by equivalent moral agendas.

541. For example, see aspects of the U.S. MK-ULTRA programme that I previously referred to on page 115. This covert CIA funded programme involved the use of incarcerated IDU, along with other types of inmates, in medical and psychiatric experiments. Accounts continue to be corroborated by ongoing research. According to Blumsohn: "MK-ULTRA research was carried out with the quiet acquiescence of official medical bodies and with the active collaboration of many individual academics. Many individuals were awarded high honours, and no physicians were ever punished. Despite attempts to destroy MK-ULTRA records [Memorandum regarding destruction of MK-ULTRA documents in 1973 (1975), Summary Of Agency Records Retrieval (1994), Helms (1978)] much documentary evidence is available and the names of many of the involved academics, universities and hospitals are now known. On my way through MK-ULTRA documents I noted many names. A majority were doctors." (2007). Blumsohn draws particular attention to Dr Ewen Cameron, a psychiatrist who worked at the Allen Memorial Hospital at McGill University. Dr Cameron carried out experiments involving induced trauma with no primary

systemic logics of health professions and political governance are required, in terms of their own goals of effectiveness, efficiencies, and defence of jurisdictions, to oppose such infringements. Injection not only creates general health hazards, but does so in two sites that have been jealously guarded as medical jurisdictions. One site consists of places where medical equipment is used without prior professional approval. The other site involves activity intended to reach inside human bodies and minds. Illicit privatising of these sites reduces the authority as well as the legal territory of health professions. Such institutional factors influence the shape and workability of boundaries between health and justice systems, despite becoming increasingly problematic due to modern body practices of altering functions and appearance for non-medical reasons that may well be recreational or performance enhancing.

Conventional drug treatment services have an interest in treating IDU as being irrational, 'out of control', incompetent as an adult and a parent, being incapable of citizenship, and with reduced human rights to self-determination. These ascriptions have been partly due to diagnostic protocols that define the breaking of drug laws as a component of mental or behavioural disorder, despite many drug users participating competently in 'normal' everyday life activities.⁵⁴² Such diagnoses reinforce the control of IDU by health professionals, complemented by policing activities designed to raise illicit drug prices, to supply patients through the justice system to drug treatment industries, and to incarcerate non-compliant IDU patients.

Professional drug treatment frequently involves reinterpreting or discounting the content and meaning of a patient's speech (Curra, 2000:149-187). This silencing seems partially due to the incentives for drug users to mislead those who control access to drugs or therapy, combined with the incentives for health professionals to ration services and not be misled. The deceptions attempted by the CIVDURG co-ordinator on her treatment providers as well on the Medical Officer of Health and the District Pharmacist, as described in chapter 7, illustrate these incentives. Such medical and psychiatric logics seem to position IDU as equivalent to patients with mental health problems who may need to be committed against their will. Both sets of people have been treated as being incapable of autonomy in everyday life, including the autonomy of publicly speaking for themselves, about themselves, and have their speech taken at face value in the absence of contradicting evidence.

therapeutic goal and without the informed consent of the subjects. Similarly to the 'Unfortunate Experiment' conducted by Dr Green at National Womens Hospital (Cartwright, 1988), Dr Cameron's experiments on non-consenting patients for over 20 years were also well known to his colleagues. Some were even published, yet with no professional critique, no public accountability, and no comment from McGill University. This silence seems related to Dr Cameron having not only U.S. Government patronage, but also having been a president of the American Psychiatric Association, and of the Canadian Psychiatric Association, and of the World Psychiatric Association, and other professional bodies of status. The relations and potential relations between IDU, clinics, psychiatric professionalism, institutional torture, incarceration, and health research are clearly of significant intensity and deserve further study.

542. See, for instance, Satel (2001: 118-143), Heymann (2001: 81-117), Curra (2000: 149-159,172-173), Keene (1997: 12-13), Courtwright (1997), Kirk & Kutchins (1992: 226).

In both drug treatment and mental health treatment, specialists can, by applying a diagnosis, gain control over a patient's self-representation in public. Treatment professionals effectively represent their patients, by excluding or reducing the status of other forms of representation which might be chosen by a patient. Many such professionals would only do so reluctantly. Notwithstanding, the professional NEP stakeholders have complained at times about peer-professionals' similar representational advocacy on behalf of IDU and their criminal activities. For instance, the Pharmacists' Society spokesperson made a written complaint on this issue, on behalf of the profession of pharmacy, citing peer-professional condoning of "the illegal use of illicit drugs" (Galloway, 1998: 1).⁵⁴³ Whether such condoning had led to more harm or more health was not evidenced or argued, and seemingly irrelevant to the complaint.

The problem of representation clearly interacts with professional interests in protecting their private jurisdictions of care from any intrusive evaluation from outside. Pharmacists in 1988 objected strongly to their NEP colleagues being evaluated from outside their profession according to how they were perceived and evaluated by their IDU clients. Such evaluations might come not only from other professions or officials, but from groups of service consumers, or in situations when peer-professionals advocated for IDU in treatment. Where IDU have been socially criminalised, stigmatised, and 'put in their place' as requiring treatment or incarceration, they have been supported by doctors and treated as patients, in accord with professional ethics of caring for individuals. Yet when IDU became collectively represented through the NEP peer-professional groups, boundary conflicts emerged between IDU as clients and as patients. For instance, peer-professionals have represented and advocated for the IDU clients of doctors.⁵⁴⁴ Peer groups such as ADIO directly advocated for improved methadone treatment clinics. Other groups, such as DIVO, formed separate support groups for methadone consumers. Department officials recognised in 1988 that the peer representation of IDU was essential for the NEP to be effective. This recognition continued in later Ministry of Health reviews of the NEP (Walzl, 1994).

I now refocus from the general oppositions between established health professions and IDU, towards a closer study of the boundaries where such antagonisms are actually experienced. This

543. Such concerns might explain why so few Level 1 pharmacists have wished to become Level 2 outlets, which are effectively evaluated by IDU peer-professionals on behalf of both IDU and state funding agencies. However, 30% of NEP pharmacists have actually complained about not receiving adequate educational or other support from NENZ (Sheridan et al., 2005). Professional conflicts of interest might also explain why few primary practice doctors initially participated in the NEP and why in 2005, the number has been zero.

544. Peer-professionals have been capable of maintaining resource bases that survive the death of any individual client on a methadone programme. Peer-professionals have also acted as intermediaries in providing links to a wider cultural and institutional environment of patient rights. This area has overlapped with the feminist project of asserting women's rights to subject a male dominated medical system to surveillance, and to provide alternative forms of health care. These movements have, from the 1960s, subjected medical professions to social scrutiny and political accountabilities. In New Zealand the 'Unfortunate Experiment' at National Woman's Hospital established an awareness of misplaced trust in medical professionalism that erupted at the same time as the NEP, and continues as a powerful symbol of the potential dangers of 'clinical governance' that lacks strong peer review and direction by independent Ethics Committees.

shift connects the institutional understandings of the types of expertise based upon qualifications to the everyday practices involving local knowledges, personal experiences, and group norms. A crucial activity of the NEP has involved the circulation of intermediaries through regular work, in ways that continue to reinforce a trust that is simultaneously peer-based and professional in its goals. As I have shown in the chapters on the details of the historical developments, there have been more than a few intermediaries. This is important when I argue that the number of circulating intermediaries has added to the normality and stability of the peer-professional practices of the NEP by enrolling normal aspects of licit commercial, official, and health professional systems.

These intermediaries have included sterile syringes, IDU, peers, drugs, knowledge of hazards, statistics of risk, drug using practices, funding agencies, contracts, returned syringe samples, money, documents, reports, claims of representation, financial statistics, and meetings. All of the intermediaries have been actively aligned in relatively stable arrangements, indicating the presence of boundary effects along with the processes of circulation. The maintenance of reasonably stable boundaries in the NEP has depended upon how these assemblages of circulations have been managed. This has provided a systemic environment that has driven and shaped activity, as in a fuzzy and flexible mechanism, by linking the needs of a network of stakeholders to the availability, inscriptions, and potential meanings of syringes as actants, and to the personal needs and motivations of human actors. This activity can be understood as deriving not only from structural opportunities for interactions between interested parties, but also from the interplay of motivations with contingencies.

These intermediaries show how the productivity of peer-professionalism derives from the way that illicit and stigmatised aspects have thereby become both sanitised and useful in terms of conventional understandings. The NEP usefully illustrates such conceptions by being hybridly intense in general, and by providing the conditions for the development of IDU peer-professionalism as an odd new form of occupation. The NEP's hybrid goals of motivation change alongside the movements of syringes have necessitated peer-professional interconnections.

Syringes have transported drugs from the outsides to the insides of bodies, while possibly facilitating the jumping of contagious viruses from host to host in a 'hypersea'⁵⁴⁵ of fluids and policy nets. Yet syringes have also acted as the material body of such nets, blocking the movements of viruses. Syringes have acted as significant constituents of the generative matrix of this complex, partly ecological, partly institutional environment. Syringes have, in their shifts of

545. Life developed in the sea, where compared with later land living organisms, transport of water-borne chemicals and nutrients was more pervasive and largely unspecified due to organisms living inside the medium. Later land living organisms evolved internal 'seas' that were much more specified and channelled, for instance the reticulation of blood vessels. Nonetheless, each organism carried and extended a node of a disjunctive, distributed sea. The nodes could connect at times, for instance in the transmission via syringes of blood-borne organisms such as HIV and HCV. This pattern of relationships between environment, fluidity, organic shapes, and the movements of organisms can explain aspects of the evolution of diseases and co-evolution of parasitism and symbiosis. See McMenamin & McMenamin (1994).

meaning while circulating across institutional boundaries, constructed a tangled, stranded non-linear matrix, which can be understood as a trapping net. This net traps the syringe users, peer-professionals, health officials, and health professionals in a particular pattern of articulation which is not notably enjoyed by any of the participants, yet which continues to exist. Syringes, in other words, are not an alternative process that merely complements peer-professionalism. Instead, syringes in part constitute peer-professionalism through a distributed pattern of embodied interaction. Syringes have embodied peer-professional practices of motivation changing through material movements that have legitimised, extended, and intensified the presence of the human peers. This situation seems strangely unique, yet deceptively normal.

3 Where are peer-professionals coming from?

The NEP illustrates how the resourcing of illicit private activities in order to protect public health has been initiated, then made politically sustainable, and so become a source of on-going policy development. As described in previous chapters, this situation and process has been made feasible by a new occupation of peer-professionals who maintain trust relationships despite of and due to the institutional antagonisms between key groups such as IDU, police, medical professionals, and officials. The maintaining of trust involves ethos and ethics, by linking individual IDU motivations to a community identity of shared practices and normative values. However, the method of using ‘activated’ material objects, in the sense of carrying inscribed meanings and circulating to where officials and professionals cannot, provides a general instrument, or design principle, potentially applicable in other situations. Three factors involving professionalisation have been crucial to the development of a specifically IDU-related hybrid assemblage, or mechanism.

First, the existing professions avoided the area of work that directly engaged with the crime and stigma of injecting drugs. It is understandable, despite individuals from a social work background finding long-lasting employment in the area, that social work as a system of organisation did not become the foundation of syringe supply. It is even more understandable that the addiction treatment industry, or sector, rejected proposals to set up syringe supply. The only professionally legitimate way for a medical doctor or treatment counsellor to approve of syringe supply was if it was under complete medical control. This option implied injecting rooms where both syringe and injecting would be medically supervised and counselling available. That these were introduced elsewhere shows they have not been intrinsically impossible, but that they have not been introduced or seriously discussed in NZ shows that they are extremely difficult in terms of gaining support from policy-stakeholder networks. With no political support, doctors and nurses could not establish injecting rooms to a clinical standard even had they wanted. This left many health

professionals with a choice between rejecting or ignoring the NEP. Although a few medical specialists were supportive, the numbers were insufficient.

A second factor has consisted of the development of the IDU peer employees and trust boards in a professional direction.⁵⁴⁶ A third factor has consisted of the need for peers to not only professionalise, but to remain closely engaged with IDU and crime worlds. Although the peers developed expertise and competencies in their new form of work, their core expertise consisted of their experience. Such experience was not a generalised, theorised type of expert knowledge, yet it was attuned to professionalism in being personally applied, by discretion rather than by rote.⁵⁴⁷

The criminal aspects of drug use prevented over-professionalising by subordination or assimilating into the existing specialties, but so also did the recruitment practices of the NEP. This was because professionals are concerned to maintain the trust of public and politicians, while nevertheless developing a select group of problems matched to clients who otherwise can perform as everyday members of the public. Since IDU clients were already existing as a problem and a labelled group, there was less scope for adaptability in a future development of professional boundaries. The boundaries were already largely set. The development of professional characteristics was required to make settlements and accommodations with the criminal aspects that could not be escaped from. The peer-professionalism was limited and channelled in these key dimensions.

The peer-professionals who founded peer exchanges were strongly self-motivated. In Auckland, Christchurch, and Dunedin, being the sites of the NEP groups I focus on in this thesis, each founder actively pursued a career, though with different competencies and over the different periods. Others, who entered the field later, also wished to advance careers. Given the professionalising tendencies I have noted, along with the sheltered nature of the occupational environment, career development is hardly surprising. What is more interesting is that such potential careers were not promoted by state agencies. The initial problems of the peer groups emerged from external constraints that conflicted with the external pressures and career prospects for improved effectiveness and efficiency. I have found no records to indicate that the Department and Ministry officials considered this issue. It would seem that career opportunities would stabilise a field of work, and accordingly, might be supported. However, the overall health sector changes have positioned stability and careers far lower in the priorities of governance than labour flexibility and cost-capping.

546. Although not an argument I develop, since its influence is difficult to measure and does not clearly emerge as forceful, existing theories of patient-centred practice (Stewart, 2003), phenomenologies of nursing (Crotty, 1996), and biopsychosocial practice, have been drawn on by certain participants during the early development of the NEP environment. See also Beresford (2005), Double (2005), Tew (2005), Carr (2005), Frankel, Quill, & McDaniel (2003a, 2003b), Wynne (2003), Brown (2003), Engel (1982), Engel (1980), Engel (1977).

547. By emphasising experience I do not suggest that the NEP environment was necessarily anti-theoretical. It was simply under-resourced and too busy surviving to strategise theory in a strongly commercial environment featuring shrinking funding levels and other neo-liberal constraints on central governance.

Although professionalising tendencies have been observed amongst the specialised working practices and institutional environment of the NEP, several generally acknowledged aspects of professionalism seem to be missing. The conventional understandings of professionalism involve several key practices and logics. One is of maintaining public and clients' trust. Another is of reliance on governmental support for a monopoly, despite not being a state agency. The third consists of an infrastructure to regularise the training, testing, and qualification process to maintain and improve the theoretical foundations and best practices of a profession. This infrastructure supports the public trust and the relations with government by providing a monitorable mechanism by which the cultural reputation, market impacts, and the discipline of members can be controlled.

The NEP has not featured an accountability structure organised around a professional body for peer-professionals, apart from their employment which initially depended more upon official regulations and latterly more upon corporate management requirements. There has been no direct peer or professional accountability to IDU networks, nor to any health professional body.⁵⁴⁸ Low overall numbers of peer-professionals, and expectations that career structures would be uncertain, have encouraged a volunteer rather than a committed work-force. Yet unlike in most professional situations, the market for peer-professionalism does not have to be defended and nurtured. Accordingly, the observed constraints on trust and accountability in the NEP have been largely due to the lack of a professional qualification, based on monitored training.

Attempts to provide training for NEP peers have come up against a range of problems. NENZ does act as a professional body by setting standards and advocacy, but is not proclaimed as such, and is also a contracting agency.⁵⁴⁹ Throughout the NEP, and even in NENZ, there are only relatively low numbers of employed and volunteer personnel. This situation is unlikely to change so long as budget constraints are interpreted as requiring reductions in peer personnel and outreach activities. Yet the expansion in peer group numbers has created a need for administrators who are acceptable to peers as well as to Trust Boards and state funding agencies. The hybrid ambiguities of needing to have experience in illicit injecting practices creates significant barriers to becoming named and recognised as a qualified peer-professional. Lack of anonymity explains why NEP peer outlets have not been sustainable in small towns, whereas the 'invisible networks' of peers in the West Coast 'bush-net' scheme⁵⁵⁰ have proved highly successful. Peer training is further complicated by the absence of a cohering theory for what peer-professionals do, how they should perform, and how problems should be addressed. Such difficulties are increased by the uncertain employment

548. There is no Peer-Professional Association of Aotearoa/New Zealand. Such a body could link to NENZ, retain the histories and skills accumulated over decades of experience of harm reduction work, could provide mentoring, would not compete over resources and territory, and would provide a wider forum than a small number of high-level representatives. Such a body could fall outside a peer-professional niche.

549. Some of these have been described in chapter 7, from my experiences on the CIVDURG Trust Board where I attempted in 1990 to outline the training needs.

550. See Ch. 1, S2; Ch 9, S4; Ch 10, S3.3.

prospects and the spontaneity associated with drug use, even if no dependence or abuse is involved.

IDU with appropriate professional skills experience strong incentives not to become involved in the NEP because of the harms associated with medical and criminal stigma. However, the need for greater numbers of professionally skilled IDU increases as the NEP coverage and services extend. The gap between needs and numbers has been due to state agencies rationing the funds available for peer-professional types of NEP activities that, in being educational, or outreach, or administrative, were not directly self-funding through the user-pays syringe supply. There been no secure funding for employment or for the training of those employed. Nonetheless, NENZ does allocate funding for annual meetings for the peer group managers to liaise and share ideas (Henderson, 2007. pers. com.). NENZ had also been involved in a training initiative for a methadone treatment and maintenance system run through GPs, and not restricted to privately administered clinics that have monopolised the service delivery and treatment logics of methadone in New Zealand.⁵⁵¹

Certain of these problems of training for quality practices were ameliorated by the formation of NENZ. Furthermore, the later promotion and establishment of regional blocs, where previously autonomous groups and newly formed groups were established under the management of a group in a different region (Henderson, 2007. pers. com.) has reduced the logistical problem of finding suitable administrators and Trust Board members for each peer centre. Yet the regional bloc infrastructure differs from the NENZ infrastructure in terms of its professional autonomy and collegiality, versus its hierarchy and employment. Regional bloc formation also undercuts the peer logic of autonomous groups being dependent and responsive to local illicit drug markets and social conditions. Other problems of representation have emerged from each group being nominally autonomous and casting a separate vote on the NENZ board.

Although the peer groups have previously been contracted to supply forms of regional representation, that requirement seems to have been reinterpreted by the Ministry of Health's support for wide-region administration of the peer groups.⁵⁵² These changes risk detaching the hybrid logics of peer-professionalism from their local embedment in IDU networks. This is because such networks are illicit, are completely autonomous, and are unable to be controlled from official centres, such as the Ministry or a corporate Trust Board. The hazards and opportunities of such developments provide a persuasive motive to use a peer-professional

551. This training programme was attended by three peer-professionals in management positions in the NEP. However, this initiative was abruptly cancelled by the Ministry of Health in 2005. The cancellation seems due to the political competition between senior practitioners for funding and influence over ongoing training and associated sector development (Henderson, 2007. pers. com.).

552. The continuing Ministry support for a 'regional bloc by stealth' strategy suggests that the peer groups might no longer be desired by health officials to be constituted as separate corporate entities with separate contracts. How this trend combines with the changed financial arrangements consequent on free 1-4-1 supply will be interesting to observe.

perspective in evaluating the potential harms. The question of where peer workers are to come from supports, by its compelling relevance and difficulties, arguments that peer-professionalism has characterised rather than merely featured, amongst others, in the capabilities of the NEP.

The founding NEP goals and subsequent developments have worked through the trust of IDU. If IDU were expected to participate, they needed to trust, or be offered guarantees, that state agencies such as the NEP would neither identify them individually, nor cause increased arrests in their communities. If not, IDU would be publicly presented as incompetent to evaluate and control risk, even though empowerment through maximising control over drug using risks has remained a core goal of the NEP strategy. Later government policies have promoted greater information sharing between health and enforcement agencies. This integration has linked the harm reduction and abstinence logics by means of surveillance data derived from their associated implementation and evaluation practices. The linking of regular NEP outputs and sporadic client surveys to enforcement agencies, in a seemingly unplanned policy, would seem to risk the trust relations which health surveillance programmes, such as the NEP, depend on for their core sustainability.

The NEP history has offered warnings about exceeding its peer-professional parameters. Assuming that injecting drug use remains highly criminalised, these issues provide operating points for evaluating where the arrangements between peer-professionalism and the more conventional implementational roles of the NEP are shifting towards. CIVDURG illustrated the difficulties of attempting to professionalise without accepting the requirements of connectivity and accountability to multiple colleagues. When these requirements ceased to be met, the sustainability, stability, and shape of the group disappeared, in that order. Peers are essential for a motivation change based programme, and professionalism is essential for such programmes to be effective and efficient, as opposed to cheap in every sense. Yet peers and professionals are divided in many ways, just as the health and crime environments of blood-borne disease transmission are divided in related but different ways. After a promising beginning, CIVDURG failed to professionalise, both across its organisational boundaries and within its Trust Board. It failed for peer type reasons.

4 Peer-professional hybridity: Linking case and concept

The national planning of the NEP has seemed deceptive, in that the critical boundary work was experienced in small and hidden sites, such as the houses of IDU, and in the illicit pharmacies which supplied syringes before becoming extended, formalised, and resourced through regulation and funding from state agencies. However, although such stages occurred, and were shaping, it need not necessarily have happened in the way observed. It is necessary to look at the boundary work to understand the causes. The developments were pushed and pulled, but not by the stages

themselves. However the staged shifts of environments, along with peer-professional logics, made some options more difficult than others. The extension of the NEP from an illicit to a state supported programme was eased by a staged development that began in a small-scale site of regular activity. Within the sites of pharmacy, better supported constituents such as pharmacists and officials could be joined and become sufficiently stable to attract and protect more vulnerable constituents, such as IDU peers and peer group outlets.

The boundary reconfigurations of the NEP developments that I have described have been highlighted by the circulation of syringes and other objects in patterns that constitute an actor-network. The actor-network influenced analysis presented in this thesis has described how the NEP has been discretely influential in changing its own conditions by influencing policy while delivering needed health services. I have shown how a professional type of influence over conditions of work has been largely due to the capabilities of peer-professionals in facilitating the circulation of syringes and information. In this process all the constituent elements have contributed to a single mechanism involving articulated activity and co-ordinating stories in a network effect.

The capability of acting as a single actor seems a characteristic of a profession. Yet this characteristic has derived from the need by state agencies and governments to involve and utilise IDU peers. Although the formation of a national body magnified this effect, a national body might also have taken another form, or worked through different logics and goals. Nor does the NEP seem adequately characterised merely as a single official programme, given the regional differences. Furthermore, developments have frequently come from below, driven by peers, yet aimed at professional types of goals and leading to professional types of control.

The New Zealand NEP model saw law makers and law breakers agreeing, through shared pragmatic logics, on prioritising the safeguarding of individuals and populations via public health protections. That agreement placed health professionals in a strategic intermediary position. They promoted health outcomes via non-professional service delivery organisations (Alexander, 2000), while not needing to maintain their professional boundaries against the state control of health budgets.⁵⁵³ Governments reduced their political accountability to voters and lobby groups by facilitating such NGOs (Galbally, 2000: 269-270). Despite continuing competition between professions and NGOs for health funding, many health professions were better resourced through their membership numbers and infrastructure, to influence health policy, and thus long-term funding. I argue that the emergence of peer-professionalism is usefully understood in such terms.

It seems significant that the peer type of boundary work has led to a degree of professional outcomes. This situation did not simply derive from the staged implementation, within a sector or

553. See Immergut (1992: 226-228, 233-234, 241-244), Freddi (1989), Döhler (1989), and Freidson (1984: 2).

profession, of a policy shift. Crucial illicit and informal activity preceded the formal policy shifts. This sequence of events changes understandings of what policy means and who makes it. Drugs and syringes made policy by acting as focal points for clashes between IDU, doctors, officials, and law enforcers over jurisdictions. Syringes continued to make policy by being durable and recyclable, and circulating across boundaries. The problematisation of boundaries initially preceded, and then accompanied the NEP policy and its implementation. Further NEP developments by peer-professionals also preceded their later legitimation through policy and legislative changes. Accordingly, the explanations are found more in the boundary antagonisms that have resisted closure than in the calculated cross-boundary collaborations that have contributed to the construction of smoother-surfaced edifices of seeming consensus. These explanations lie as much in the interactional structural aspects as in the path-dependent sequences of NEP development. This is why I argue that peer-professionalism characterises the NEP and its environment, instead of arguing that the NEP merely exhibits peer-professionalism along with other facets and factors. Peer-professional responses were active rather than simply a feature of the NEP. Furthermore, the concept of shapings, as both structure and sequences, provides a wider conceptual framework which supports the way peer-professionalism has been both active and not rigidly modelled.

The NEP began as focused on both IDU and professions, then steadily professionalised further while increasing its IDU peer component. The NEP goals were hybrid, with syringes desired by peers and motivation change desired by professionals. The siting of the NEP in pharmacies ensured a degree of professionalism. However, the professionalism of the pharmacists did not entail control over IDU, since the pharmacists' service provision and attitudes were evaluated in terms of acceptability to the IDU customers, and by officials who relied on information from the IDU clients. The professional pharmacist aspects then became rapidly complemented by those pertaining to the peer group outlets. The NEP goal of motivation change became provided by peers plus syringes, with less and less concern for the details and planning of such motivation change, and with more and more concern for organising infrastructure and adjusting funding levels and strictures.

Syringes became reconfigured as official instead of either professional or illicit. This process joined syringes with IDU and with professionals as semi-acknowledged actants in the needle exchange network. A small number of IDU became equivalently reconfigured into peers who worked to semi-professional standards and goals. These peer-professionals obtained state funding while retaining a high degree of autonomy. They ran centres which combined aspects of clinics and shops. They lobbied for improved health treatment for IDU. They represented IDU as peers, and as clients, and as customers. This integrated peer advocacy with health advocacy. Because injecting

drug use remained illegal, this peer-professionalism could not exist outside of a narrow niche, sheltered by health professionalism, yet also could not exist without continuing ‘attachment’ (Gomart & Hennion, 1999) to IDU. Movements in either direction were limited, and any prospective expansion was limited by health officials. By providing a workable system, with a degree of IDU motivation change, the peer-professionals provided preferable alternatives to the less effective provision of syringes through illicit methods and through health professional systems, with the methods formally separated from the systems.

Where IDU have become peer-professionals in their goals and methods, doctors and other health professionals have needed to defend or cede territorial boundaries in conventional processes that Abbott (1988) has characterised as jurisdictional conflicts within a ‘system of professions’. Because IDU are illicit, publicly proscribed persons, state agencies could only interact with them, at least at a community level, through the medium of the NEP’s peer representation. Peer-professionals have increasingly provided effective and efficient services, becoming a more valued part of a system of state activity and agency. Needle exchanges and peer representation have benefited state agencies by providing effective and efficient health services. These services have been information producing and manageable, as both instrumentality and as ‘clinical governance’ (Harrison & Smith, 2004: 373-5). Such services have provided professional and corporate forms of commodified trust (Learmonth, 2004). Syringe supply and return carried trust relations in a material form that was sold as a commodity, and so was measurable and easily monitored. Discrete devices, commodities, measurements, and monitoring all increased the trust quotient of the processes in which they have been located. These units conveyed meaningful messages of health care that mediated the expectations of trust by IDU. They also outlined the geographic shapes of IDU concentrations. The aggregated numbers and frequency of the syringes supplied and returned carried information about IDU networks and community values to health officials.

Both the abrupt turning points and the slower incremental changes might have led to collapse, or to divergence from the currently recognisable shape of NEP. Neither of these possibilities eventuated. The hybrid micro-environments of organised per-professional activities were retained as an actively hybrid niche within wider environments. IDU remained stigmatised criminals, and after a period when motivation change seemed taken for granted and not mentioned, motivation change began to regain significance due to the increased priority of HCV prevention. NEP peers could not corporatise or professionalise in overly dissociative ways, since their funding contracts required them to remain in contact with IDU, and most peers considered this a necessity. The movements of professionalising could not become too large, nor too overt, nor too dominating of IDU grassroots. Accordingly, equipment and outreach services provided by current IDU were not replaced by professional ‘ex-IDU’, nor by professionally qualified health experts, nor by a bureaucracy of

officials, nor by reliance on vending machines, nor by a deregulated convenience store.

Some significant aspects of peer needle exchange work have exhibited professional characteristics. The work practices, for instance, have been somewhat insulated from directives by markets, clients, and officials, while being recognised as involving expertise unavailable elsewhere. Other aspects, such as accreditation, have been provided through legislation and regulation. Supplying services subsidised by governments has been a standard work practice for European professional models. There is a discretionary aspect (Freidson, 1984: 1), albeit narrow, in judging the degree of peer influence to be applied in outreach situations and the degree of representation of IDU to be promoted at policy level. Yet the peer-professionalism of the NEP in New Zealand has certainly not become nearly so large and autonomous as the conventional UK and North American models of professions which are also found in New Zealand. In those situations, the collective identity of professional practitioners, along with self-control of work and training, have been clearly separated in concept from the regulation by officials and employees of state agencies. Yet such professions remain very connected to officialdom in practice, and depend upon national legislation and state agency support for maintaining their monopolies. Instead, the peer-professionalism of the NEP has been weaker and closer to a form of state agency public health work, similar in some ways to European models. Accordingly, the peer innovations need not be large nor well-defined for professionalising tendencies and strategies to be significant.

I consider the pattern of peer-professionalism to be persuasive in part because it is pervasive and repetitive at a micro-level, not only in longer-duration event cycles. This is not blind capitulation to a form of mass ‘advertising’, where repetition leads to normalising. Instead it highlights the way in which repetition indicates the activity of reproductive forces that in combination with necessity and lack of alternatives, produce the durable characteristics of experienced reality. While some aspects of durability come from forms or periods of physical rigidity, other types of durability come from dynamic processes that feature repetition along with potential aspects of cybernetic feedback. The significance lies in ‘resilience’ being adaptive as well as unchanging. The pattern of peer-professionalism is even more persuasive because its solidity involves re-articulating interactive workings of a configurational mechanism which intermeshes a set of relatively unchanging forms and relatively changing forces in regular movements. These aspects satisfy the scale and scope of my requirements for explanatory narratives to describe actual patterns⁵⁵⁴ that contribute to actual causes and effects. Yet the peer-professional aspects pervade and iterate beyond the NEP, even while explaining its particular boundaries and constraints. These aspects are unevenly distributed, yet strangely fitting as an analysis of complexity.

The NEP history from 1988 to 2007 has demonstrated stability over periods of change, despite

554. These can be considered my version of ‘social facts’. They are not ideals, nor concepts equivalent to ideals.

unresolved antagonisms and ambiguity. I argue that the hybridity of the NEP has been constitutive of such sustainability. Yet the overall hybridity of the NEP would be far less, or not exist at all, were it not for its peer-professionalism. The peer-professional conditions of structural shape and resilience have produced the characteristics of the NEP, even though other aspects and patterns, for instance the neo-liberal policy frameworks, have also been influential.

My account of the NEP's working and character has featured internal coherence as well as antagonisms. I have described how a pattern of boundary differences has connected to wider institutional and ecological environments. I have demonstrated how particular contingencies have acted as both problems and opportunities. Within its heterogeneous environment, a localised and somewhat self-supporting pattern of peer-professionalism has emerged from environmental pressures and the conditions of possibility. This pattern then influenced the later emergence of infrastructural changes which have continued to modify the NEP's niche environment.

Nonetheless, the peer-professionalism has not changed. This partly cybernetic, recursive process of activity becoming social through processes of knowing, and becoming natural through processes of modifying material environments, has demonstrated a durable solidity and stable presence, despite being based on the unstable, temporary settlement of antagonisms. Furthermore, neither the wider institutional boundaries nor the viral actants have changed. Peer-professionalism is directly connected to these actants and networks, and so by not changing, can be distinguished from the changes that have characterised the NEP as an organisation.

The pattern of peer-professionalism I have described exhibits not only solidity when observed, but has also been active within my research process by helping to generate the significant re-framings and arguments I have been discussing. The concept of peer-professionalism has emerged from my research material, addressed all my questions, and answered at least a few. The concept has opened a seemingly unexplored area of social organising to further enquiry. Peer-professionalism has neither ignored nor overridden the complexity of key aspects of the NEP developments. Instead, the concept has positioned itself within a chaotic environment as a partial consolidation of dynamic order. These aspects are persuasive because much social theorising and structuring relies on creating perspectives that present an illusion of stability by hiding the instabilities. It is better explanatory technique to parsimoniously avoid the unnecessary workarounds involved in hiding instabilities. Peer-professional explanations may involve ambiguity and complexity, but are neither simplistic nor evasive. The concept of peer-professionalism is also persuasive because the concept connects closely, at many points, to analyses developed by Andrew Abbott and in actor-network studies. Although my application and formulation of such types of concepts is original, particularly the emphasis I place on antagonisms being usefully sustainable, the concepts are grounded in existing fields of sociology, as well as in the NEP case material of repeating patterns of social

history and pervasive structural patterns.

My argument about peer-professional hybridity addresses key aspects of my initial research where I queried the capabilities of the NEP. My argument also addresses my subsequent questions about how forms of trust have been shaped and moved by means of the NEP environment, how the record of problems can be related to the record of success, whether the NEP niche has been more of an exception or more a stage of institutional development, and how to explain the seeming absence of information over the protocols and transparency of the testing of returned syringes in a context of increasingly public concerns with the ownership of personal information, familial DNA, as well as the genetic information of communities and populations. These questions also problematise the increasing embedment of the NEP within a wider, ‘whole of government’ environment of sharing information about individuals and collectives between sectors and agencies. The NEP experience of working with the distrust and desires of a stigmatised community has contributed to the logics of a ‘whole of government’ goal of including marginalised groups, equalising health opportunities, and ‘totalising’ information. Yet the productive antagonisms, observed in the NEP and more widely applicable in different peer-professional patterns elsewhere, seem to also destabilise the centralisation of an informational infrastructure of control and command. The ethos-ethics relationship observed in the NEP’s mid-level hybridity, and more widely applicable in peer-professional patterns, queries the way in which ‘whole of government’ goals may be expected to generate top-down policy moralities of effectiveness and efficiency without antagonisms.

The NEP’s hybrid settlements have responded to shifts in government, to the structural trembling of the health sector, to the unique charisma of individuals, and to graunching changes in legislation. For example, the free one-for-one scheme has shifted previous logics that depended primarily on the user-pays arrangements. Yet the relevance and consequences of such settlements and shifts are difficult to understand as sequences of events unless the peer-professional mechanism is factored in as a hybrid logic that precedes and pervades the forms and forces of its infrastructural embedment and personal embodiment. State agencies were challenged, first by the gay community organisers, then by the pharmacists who had become somewhat ‘peer’ by illicitly supplying syringes, to oppose or compete with these unofficial health services. But in becoming corporatised, the NZAF community organisation re-articulated professional and financial competencies outside of conventional professional and official jurisdictions in a new direction of community configuration, identity, and policy de-centring. In being professionals, the pharmacists who supplied illicit syringes located such challenges within a territory that was both material and moral, where competition from an official programme would need to do more good and become more expert, in order to attract greater public respect and to legitimise an official monopoly over practice and policy.

Hybridity, shaped and understood as self-maintaining instabilities, clarifies these mechanisms that describe many particularities and paradoxes of the NEP case. Since complexity and contingency characterise the general case environment, hybridity does not have to describe everything at every time, only the most significant things at the most significant times. The peer-professional representation of IDU and syringes was co-produced by the NEP's stabilising around convenient,⁵⁵⁵ predictable commercial movements. This rational process promoted a subdued accumulation of unmet health expectations for further change.⁵⁵⁶ New cycles and circulations may be expected to complement the NEP and its particular shaping of peer-professionalism as the free one-for-one system develops and adapts to the institutional and ecological environment.

In the following conclusion chapter I reflect on what the better understandings of the NEP and peer-professionalism have to offer current and on-going problems in the area of the case itself, and in terms of research methods, since my querying of capabilities effectively involves both areas.

555. Convenience does not imply being easy. The NEP's founding problems took considerable effort to overcome. Then later maintenance efforts were systematised, disguising the actual difficulties within systemic conveniences.

556. Further research that attends to the NEP might explore how much organisational change occurs before change in institutional boundary lines becomes apparent. Related research might explore whether institutional boundary lines are usefully described as elastic, pliable, or fixed.

Coda: Reflections and echoes between case and methods

“A sentence is not content with unfolding in a linear way; it opens up. This opening allows to be arranged, extricated, spaced, and compressed, at depths on different levels, other movements of phrases, other rhythms of words, which are related to each other according to firm considerations of structure, though foreign to ordinary logic - the logic of subordination - which destroys the space and makes the movement uniform. [Profound imagination] supposes a space with many dimensions and cannot be understood except according to this spatial profundity which must be apprehended simultaneously on different levels.”

From *The Book To Come*, Maurice Blanchot (trans. Charlotte Mander) (2003: 236).

The New Zealand experiences in running an underfunded, user-pays needle exchange programme that has successfully controlled HIV among IDU, with minimal political risk, might be applied in other polities. Such attempts would align with the United Nation policy on AIDS, that being to replicate and build on successes (Annan, 2005).⁵⁵⁷ By developing organisational expertise in a health provision model based on the 'whole of environment' (Smith, 1990: 2), including the social and motivational aspects, AIDS service organisations in New Zealand challenged the boundaries of professional territories, influenced health and crime policy, and secured state funding. Previous forms of 'clinical governance' were displaced by forms of lay expertise as institutional boundaries were rearranged.⁵⁵⁸ Such challenges provide an organisational focus for exporting the NEP model as a concept of policy change, but also indicate that there would be organised opposition that needed to be countered or 'enrolled'.

Hybrid mechanisms such as the NEP would be difficult to replicate as a packaged, pre-planned model because their multi-element, networked environment relies upon the institutionalised enmeshing of antagonisms. Adding to such difficulties, the necessarily urgent conditions of this environment have privileged contingencies in ways that could be learnt from, but not readily pre-planned. The capabilities I have explored emerged from the dynamic configuring of a cultural and market environment that featured complex and unpredictable aspects which were further modified by the hybrid interactivity. This environment could not be readily commodified or exported. Nonetheless, an analysis of the peer-professional principles involved can be translated into the needs and risk narratives to wherever institutional logics of secrecy and stigma require an overt abeyance, deferral, or inversion of the normal arrangements for providing care. I suggest that peer-professionals, using a peer-professional type of sensitivity, pay attention to situations of homelessness, sex-work, imprisonment, immigration, domestic abuse, mental health problems,⁵⁵⁹ illiteracy, youth community development, residents' associations, and under-acknowledged

557. Export of technologies also entails risks. The export by the ESR of New Zealand's forensics technologies to Thailand (ESR Briefing, 2004) raises human rights questions over the consequent contribution to human rights abuses in Thailand. See Ehrlich (2004a, b), Human Rights Watch (2004), Hunt (2004), United Nations (2003).

558. See Galbally (2000: 268), Malcolm (2000: 188, 1986), Scally & Donaldson (1998).

559. See Oakley Browne, Wells, & Scott (2006), *Te Rau Hinengaro: The New Zealand Mental Health Survey*.

epidemics such as hepatitis C.

The NEP's partnership model involved faith, or commitment, by: "government, community groups, medical organisations, and overseas agencies ... facilitated by political informality and, egalitarian principles, and by the relative absence of political and moral extremism" (Davis & Lichtenstein, 1996b: 223) in "working together" (Kemp 2004: 205). Yet I have shown how such coherence was based, as much on the coupling of antagonistic interests as on complementary interests, in a sequence of 'well-organised accidents'. From an IDU perspective, being imprisoned for normal everyday activities and sociability with one's drug injecting peers is extremely politicised and morally entrenched, neither informal nor egalitarian, and certainly not healthy. HIV/AIDS, and later HCV/hepatitis C, underscored this theme with pragmatic rationales that, despite the entrenched moralities of excluding drug deviants from participatory citizenship, demanded the inclusion and voluntary community work by IDU peers in the niche environment of the NEP. These 'raw edges' and corresponding 'edginess' add to the difficulties of replicating and building on the NEP's success. To overcome such difficulties requires not only commitment, but also strategic skills informed by precise, deep, wide, and critical analyses.

1 A way of working

My initial research questions, emergent questions, and analytical frameworks have been developed in each chapter as an account. The accounts have drawn on a multiplicity of sources, such as non-human objects, official publications, participant observation, interviews, and archived correspondence. However, I have not offered a different argument to different questions, because these accounts are connected within the overall articulation of my argument by my linking together concepts of a single case of hybrid assemblage and a single pattern of peer-professionalism. The analysis works by explaining case boundaries through following the activity of actants in the mechanisms and folded patterns made meaningful by the objects and participants, as described. This is 'internal' immanent explanation based on the layers and iterations of thick description. While not denying the significance of contingencies and chance, I have attempted, where persistent patterns have emerged, to generate a parsimonious account of the mechanisms involved. Complementary accounts might also emerge by drawing on different points of access and connections to the NEP network-case. Nonetheless, I suspect that recognisably hybrid aspects would appear within any sufficiently detailed and questioning account.

The institutional environment of the NEP has involved forceful constitutive elements, such as discontinuities between health and justice systems. Yet I have not observed any fully 'external' ordering force in the sequence of development stages that I outlined and analysed in the previous

chapters. Instead, I observed that partial order emerged from continuing discontinuities and antagonisms in a complex environment. This emergence draws attention to how such order became actual and embodied in the interactions of people, corporations, programmes, and legislation. I present these conditions and actants as mutually dependent, but with certain connections being more influential in the shorter term than others.

Understanding how the NEP became established and continued to work as a conjunction, despite continuing divergences between IDU and professionals, has required an extensive case study of a concentrated zone within the multiplicity of sources produced by a dynamic heterogeneous networking process. Such studies have value for exploring how concepts of ‘late-modernity’, such as the technological imperatives, the distributed identity, the risk economies, the aggregated desires, and the autonomous agency may be productively problematised, particularly in combinations.

The NEP developments are intriguing because they have acted as a constituent of a modern society, yet have emerged through the forming of a particular niche, but without requiring simultaneous pervasive changes across the institutions that outline whole social systems. My holistic environment involves multiple sites of activity which do not necessarily tie the whole rigidly together into one structure, and do not require simultaneous activity. Widely-distributed, durable institutions are not necessarily so due to being the most directly connected to underlying structural foundations, nor some type of instantaneous action at a distance, but may alternately be constructed from dynamic alliances and mechanisms of articulated local antagonisms. This framing perspective implies that institutions that seem foundational may suddenly change because their durability is an effect, not a source, nor an essence. Yet such change cannot be predicted, due to the complexities of multiple agencies, discontinuous connections, contingencies, and other non-linear aspects.

I have invited attention to the interplay of shapes and sequence. Somewhat counter-intuitively, I have found it useful to consider shapes as being active, and sequences as being static consolidations. Any event, in such terms, is always a story⁵⁶⁰ of how something became stabilised, for instance as the instrumental sequence of iterations with variations in the cycles of gay, pharmacy, peer, and commercial organising which describe the NEP’s peer-professionalism as a narrative historical development. Moreover, there is the iterative aspect of any thing, any pattern, in holding to its shape. This durability describes how things may not simply and immediately dissipate when their outside network influences diminish. In complex systems, circulations may produce cybernetic feedback that facilitates adaptive activity in the same processes that produce stability, but without any centre of calculation being needed, since the cybernetic articulations may be distributed in autopoietic⁵⁶¹ assemblages.

560. There are no counter-cases of an event that is not associated with at least one story.

561. See Mingers (1994), Luhmann (1986b), Hejl (1984), Varela (1981a, b), Varela, Maturana, & Uribe (1974) for a

A mechanism can be approached from any angle, from inside or outside, or along the interstices. The temporal activity of a mechanism, however, produces consequences that may not last, yet cannot be undone. The force that actors draw out of shaping is made immanent in the durable practices of activity, be those material or motivational, or both as in the NEP developments I have described. Mechanisms, in this sense, produce a focus on what moves and what does not, on what difficulties are overcome by the continuous activity of actors in their attempts to control the alignments of movements and to construct the illusory effect of immobility.

In my research I took up the positivist ‘tools’ of cycles, mechanisms, and models, but destabilised their associated quantitative positivism by using inbuilt antagonisms, contingencies, ambiguities, and path-dependent histories, in order to make the conglomerate similar enough to actuality to be able to follow and echo the case at hand, and afoot. This method engaged with the social imagination by following its activities using sociological imagination, ‘making a case for a case’. This makes my methods, project, and presentation of interest to the policy community, since policy-driven interventions respond to actual and predicted harms, yet notoriously produce unexpected consequences which are also actual. I argue that durabilities, intangibles, and social imaginations must be brought into conjunction within the development of policy, in order to reduce the harms of current problems, and of future unintended policy outcomes.

I have discussed the capabilities of the NEP in terms of a problematic yet productive mechanism I call peer-professionalism. These capabilities have been expressed in terms of shape (articulation of forms), stability (interplay of forces), objects (contingencies of durables and non-humans), and sustainability (self-organisation co-adapting with environmental flows). These capabilities have been seen to depend upon and assist in producing a niche within a heterogeneous yet patterned complexity. I have, accordingly, answered my initial questions about the capabilities of the NEP. I have achieved this by developing a grounded methodology which emerged amid my available sources, my question, and my intended audience. For, whatever reality may be like from a great distance, or from extremely close proximity, it is in the middle of things, through engagement with an audience, that knowledge and recognition are produced in actuality.⁵⁶² Such operational methods are useful in partly incorporating aspects of the qualitative and quantitative ontologies, while avoiding overly-subjective transcendence and overly-reductionist objectivism. Social imagination, actor-networks, and assemblages are all related in emphasising physical durability and immanence, while becoming only partially predictable due to the excess of uncertainty produced in processes of becoming through trials.

range of applications of concepts of autopoiesis. The term generally refers to self-organisation. More specific aspects include a dynamic, non-equilibrium involving forms and forces in functional states. See Chapter 10 section 4.

562. See Latour (2004, 1999a, 1999c, 1993, 1990, 1988, 1987), Kuhn (1969). Related operational and systems precepts have been described from a rather different perspective as critical realism (Sayer, 2000). I do not take a critical realist approach.

My conclusions do not encourage deterministic or hegemonic framings of understanding, except as effects produced by more local and contingent activity. The NEP did not emerge as a response to direct institutional needs. Instead, it emerged as a response to a particular problematisation of HIV/AIDS which threatened a majority grouping, while offering scope for creative policy entrepreneurs, within an institutionalised environment. Large numbers of people wished to ameliorate this problem while changing as little else as possible. By being material and local, both as a peer-professional occupational niche and an organisation, rather than an institution or a 'counter-institution', the NEP rearranged boundary connections, but only within its own bounded zone of permitted activity. The question of whether drug treatment and law enforcement areas have been significantly influenced by needle exchanges in general, by the New Zealand NEP, by harm reduction in general, and by New Zealand versions of harm reduction, seems to remain quite open.⁵⁶³

My analysis suggests that the very success of the NEP has obscured core aspects of shaping and sequencing. This obscuration makes it difficult to understand how the NEP capabilities had worked and been maintained. Such difficulties have impinged on research into the NEP, yet also, relatedly, will impinge on policy-making if that is to be evidence-based. For instance, I noted how in 2001 it had become possible to call a strike to support demands that the Ministry of Health enter genuine negotiations to increase the funding needed to reduce the financial barriers that constrained the syringe return rates and diminished the quality of the NEP services. Yet the original *NEP Management Plan* in 1987 had specified consultation while specifically excluding negotiation, in order to stabilise the NEP by ensuring that its financial arrangements remained rigid. Consultation involved a promise to listen, with an open mind. But consultation did not involve any directive for the Department and the later Ministry to relinquish their capabilities and accountability to command and control the NEP's regulatory and funding relationships.

The feasibility of the threatened strike demonstrated how the peer-professionals had attained control over the crucial everyday systems of the NEP. The aftermath of the strike threat, while costly for the NEP in terms of losing a skilled strategic administrator, has confirmed the significance of these systems in terms of peer-professional types of capabilities. Though the strike threat did not succeed directly, it forced the commissioning of the genuinely external review in 2002. The review revealed that the Ministry of Health claimed to be unable to access any financial data on the costs of the NEP. This claim has illustrated a lack of evidence-based evaluation, which undercut the long-standing objections by the Ministry to proposals for service improvements. The review also provided a rationale for a new Minister of Health to overrule the Ministry advice to

563. Harm reduction concepts seem to have challenged some treatment fundamentals of obligatory abstinence. I have noted treatment practitioners being careful to specify that they are experts in problem drug use, understood as evidence-based problems, rather than using language that defines all illicit drug use as abuse or misuse.

oppose the release of funding for a one-for-one syringe exchange system. The strike threat, accordingly, exerted a clearly observed, forceful effect, yet was controlled sufficiently to remain in the private NEP policy world, outside of the public domain and media access. This combination of force and control somewhat explains the urgency with which the Ministry eliminated the NEP co-ordinator who organised the strike, yet whose job depended on the continuation of Ministry approval and funding. The strike attempt has provided not only a key question but also an emergent boundary to this period of NEP history. It illustrates, as the boundary of a meaningful event, both destabilising and nurturing capabilities. The strike helps to understand processes of structuring and sequencing the capabilities of the NEP in terms of professionalism, accountability, and trust. Nonetheless, the strike threat was only a single incident amidst a long-standing settlement where the contributory antagonisms were mostly underplayed.

The formation of the NEP was shaped by earlier conflicts between community organisers and health professionals, followed by the withdrawal of health professionals from control over the NEP's new areas of work (Alexander, 2000: 161-4). Well known professional tendencies towards collegiality within similar areas of expertise, and collaboration between different areas, did not eventuate. Nor did an equally well-known overt struggle over professional territory become expressed once the NEP had taken solid form as a peer-inclusive set of goals and methods. I have described the more significant conflicts over professional territory, together with the important benefits to the NEP caused by the reduced levels of the professional control of health care in this area.

The significant point is that, unlike the conflict between the NZAF and the sexually transmitted disease industry, or 'sub-profession' over control of HIV/AIDS policy from 1985 until at least 1991, such conflicts did not continue beyond the formative stage in the case of the NEP. One reason for this has involved the differences between the IDU and gay communities in their relationships with STD treatment practitioners. The STD practitioners had been forced by official decisions on the HIV/AIDS prevention programmes to publicly acknowledge the non-compliance and distrust experienced by the gay community and expressed by community representatives. After this exposure, the STD treatment profession attempted to alter their system of attitudes and relationships with homosexual patients, or at least claimed to be doing so to the state agencies that licensed, permitted, and funded their professional privileges and practices. By contrast, individual practitioners might be sympathetic to IDU patients and ignore certain inherent conflicts with their professional interests. But this tactic could not be employed by professional bodies in the case of patients whose drug injecting practices remained criminal and who remained opposed to the medical control of 'their' private substances. This situation with IDU contrasted with the way homosexual practices had been decriminalised and no longer officially labelled as harmful in 1986.

The gap between IDU and health professions was not directly closed, due to the gap between criminal drug users and health professionals actually widening. Instead, the NEP indirectly and partially bridged this gap, somewhat hiding it and somewhat drawing attention to it.

When the NEP was being founded, New Zealand health policy was responding to low and highly unequal levels of the public utilisation of health care (Malcolm, 1997), by attempting to: “empower communities both to provide and to contract for their own primary health care services” (Malcolm, 2000: 189). However, when communities such as IDU have been marginalised, and become vulnerable to health problems due to stigma and secrecy, health sector policies of ‘community empowerment’ have conflicted with the traditional criminalisation policies of isolating the members and representatives of communities defined as criminal. Yet such exclusion from public spaces, resources, and rights has also excluded people from public health networks, except for additional forms of labelling these people as ‘needing treatment’. Moreover, the concept and usage of the concept of community has referred to a ‘settlement of differences’, since: “... ‘community as an ideal often masks conflict, division and dissatisfaction’” according to Ryan (1991, as cited in Lindberg & McMorland, 1996: 117). If such communal aspects had not already come together, one would expect to find antagonisms which resisted being assimilated and bound up so neatly to form a singular community entity. If the expected benefits balanced the antagonisms, a hybridly knotted environment or a rhizomal assemblage,⁵⁶⁴ as in my analysis of the NEP, does not seem surprising.

In this NEP account of institutional reality, things could also be something else, depending on where and how the boundaries come to be drawn. The most intense example has been the strike threat, which was perceived by officials as sabotaging the NEP, yet driven by peer-professionals through a goal of restructuring the NEP to address long-standing gaps in service delivery. An earlier illustrative event is seen in the way that CIVDURG in 1994 was understood to be dysfunctional by other AIDS Service Organisations, yet was applauded by officials of the Southern Regional Health Authority for meeting its required outputs. One can also observe shifts in the prioritising of outreach by three sets of actors. These have been the IDU clients, the peer-professionals, and the officials who controlled the NEP’s funding contracts. In these arrangements, the capabilities that connected across several generally distinct policy areas (Murdoch, 1995: 747), including the regulation of markets, the regulation of professional autonomy, and the balancing of official privileges with accountabilities, have also shifted.

The process of forcing community development would necessarily add particular forms of order

564. For seminal work on rhizomal models, and relationships between smooth nomadic spaces and striated ‘institutionalised’ spaces, see Deleuze & Guattari (2004: 3-28). While appearing as cultural philosophical analysis in *A Thousand Plateaus: Capitalism and Schizophrenia*, concepts of rhizomal formations have been appropriated by certain ANT writers and applied to more detailed, empirical case studies. As I appropriate Deleuze & Guattari, rhizome refers to a non-geometrical and somewhat contingent dynamic structure of multiple elements, yet simultaneously to a convergence and consolidation of such elements into particular bodies of meaningful activity for change. The concept is opposed to arborescent models, such as form the underlying static logic of tree diagrams.

and uncertainty to an already complex, messy reality. These additional programmes and organisations would seem like contingent events, yet also like increases in complexity, and also as if simplifying from multiplicity by focusing onto a single programme or named community. An analysis of all these together, especially as a cross-section of a longitudinal historical process, risks confusion. Yet a closer following of the detailed forms and forces of effects potentially resolves such counter-intuitive confusion into readily followed and understood events. As I have shown, analytic narrative offers a way of extracting relevant features and patterns from such confusion.

2 The continuing significance of the NEP's gaps

In this thesis I have identified key concerns for the immediate future planning of the NEP, or for allowing it to adapt and develop without planning. Some of these issues have wide implications, for instance where empowered communities produce governance by other means than entering into the hierarchies of formal state agencies. In these other, more heterarchal processes (Fougere, 2001) and active linkages, forms of grounded, self-help health care can both challenge and supplement private or public health provision, while distrust in the recording of personal and collective details interweaves with the proposed effectiveness and efficiencies of a 'whole of government' policy. The shifting NEP capabilities, such as electronic syringe dispensers, in the areas of regional infrastructure, career structure and training, and the provision of services to prisons and schools, seem more inherently localised to the existing NEP sites of activity. Yet other issues, such as population-based strategies for reducing the transmission of HCV, and links between IDU and conventional drug treatment services, lie ambiguously between the local case of the NEP and its wider constitutive environment.

Better understandings of the NEP have been complicated by gaps in policy frameworks, in records, and in service delivery. Such absences seem crucial rather than merely incidental, as illustrated by the gaps in the legal status of the syringes purchased at NEP outlets. These syringes are legal for peer-professionals to transport and distribute but not necessarily legal for IDU clients to 'possess'. For instance, in 2007, a community newspaper casually reported an IDU being charged with the possession of such syringes, with no suggestion the syringes were obtained from anywhere other than a licit NEP outlet (Latz, 2007: A3). Such regular instances appear as patterns in the data on IDU held in police cells. This data was gathered by Lifelinks, a treatment-oriented agency, as a standard activity in their partnership with police in the Arrest Referral Scheme.⁵⁶⁵

565. See Appendix 3. The Arrest Referral Scheme only ran for a year in Canterbury. It was funded by police and its two workers were organised by Lifelinks. Lifelinks is a private agency contracted by the Ministry of Health to provide needs assessment and service co-ordination for people with disabilities in the Canterbury region, in ways that best suit their individual needs. (Lifelinks, 2007). The direct approach of agency workers to people in police holding cells, who may not have received legal advice or been de-toxed, raises questions of the degree to which informed consent to release private information, and 'hunting for clients' practices might be involved. Without sufficient

According to the Arrest Referral Scheme data, in nine months during 2005, eleven people were held for possession of needles and syringes in the Canterbury region. This possession of needles and syringes charge comprised the second largest category in a 115 case sample of persons held in police cells. The largest category was ‘male assaults female’ at fifteen recorded arrests, and next lowest was procuring or possession of cannabis, at nine arrests. (See Appendix 3).

The types of charges in this sample were commonplace, suggesting that this sample and its framework has been typical for longer periods, and possibly other regions. Data of this sort had been requested since 1995 by Needle Exchange New Zealand (NENZ) (Blacklock, 2003. pers. com.) but continued to be refused by police authorities, who claimed that it would or could not be provided (Henderson, 2007, pers. com.).⁵⁶⁶ These incidents illustrate a pattern of syringes being legally and culturally framed both as ‘drug-using paraphernalia’, and as a ‘licit object of NEP legislation’, yet in antagonistic ways depending on the agents, attitudes, and associations of the situational context.

The risk of arrest or harassment creates an incentive for IDU not to keep used syringes for return to the NEP. Yet the need for the NEP is only created by IDU being illicit and stigmatised. The NEP itself only exists because the police stated their support, yet the police also directly undercut the NEP’s public safety goals. My account has described how these patterns and incidents feature in the longer view of the character and landscape of the NEP.

A further gap appears in the way injectable drugs have been readily marketed in prisons, compared with the policy of successive governments of preventing access by inmates to sterile syringes. This situation forms a ‘trap’ for IDU because motivations for drug use are increased by prison overcrowding, boredom, fears of violence, peer drug use, and official corruption. Worsened mental health problems, or similar ‘normal’ responses to abnormal situations (Hager, 2001), seem relevant to prolonged exposure to traumatic prison conditions (Office of the Ombudsmen, 2005), and are known factors in the increased use of both licit and illicit substances. This carceral situation, no matter its causes or proposed benefits, has constituted a public harm, for instance from increased transmission of other blood-borne viruses, such as HCV. Public harms seem likely to have resulted from the bureaucratic boundaries which have embedded the logic of isolating inmates, as overriding the logic and ethic of equal health care for all, in the objects such as bars and locks that constitute a material prison. Nonetheless, in 2007 a national newspaper published an article

numbers of clients, agencies such as Lifelinks have difficulties in accessing funding. Schemes such as the ARS generate solid client statistics for such agencies without relying on the clients’ fully voluntary participation. Links between law enforcement, citizen compliance, and health provision are highlighted in such areas where people find themselves trapped between the constraints of crime worlds and health worlds. Such difficulties may explain why Lifelinks personnel refused or were unable to respond to queries by the NEP co-ordinator on the syringe arrest statistics being gathered (Henderson, 2007. pers. com.).

566. Claims by police that information on syringe arrests was either not recorded or unable to be separated from other data (Henderson, 2007. pers. com.) have not been credible, as eventually demonstrated by the ease with which Lifelinks researchers funded and supported by the police obtained such data.

containing excerpts from a study undertaken in 2004, commissioned by the Ministry of Health. The study involved a collaboration between the Christchurch School of Medicine and NENZ. The principal researcher was Charles Henderson, National Manager of the NEP, a peer administrator employed by NENZ. According to the article:

A survey of 412 clients at nine needle exchange centres around the country found 45% had spent time in jail and 25% had been in prison in the previous year, 40% admitting to injecting illegal drugs while inside, including methamphetamine ... and opiates such as heroin. ... Imprisonment was identified as a key risk factor for hepatitis C: 80% of respondents who had served time in prison tested positive for exposure, compared with 60% of users who had never been to prison. ... Henderson said that while there was widespread support among prison health workers to extend needle exchanges and other measures into prisons, it remained a political issue. ... Drug Foundation executive director Ross Bell [said that] inmates should have access to the same rehabilitation and harm reduction services available in the wider community - especially in view of the high rate of hepatitis C infections in the prison population.
(Hill, 2007:A4)

The article publicly presents the NEP as capable of ‘breaking into’ and scrutinising prisons through contacts with illicit IDU. These IDU network connections undermine the prison boundaries that block epidemiological research “with rather than against” inmates (Lange, 1987).⁵⁶⁷ By carrying out such professional health research, the NEP co-produces contentious knowledge with forceful policy actancy. This capability seems innate to the NEP’s hybrid mechanism of linking syringes as objects with syringe-users as subjects in professionalising processes.

At this point I invite attention to the prospect of completely removing the peer component, thereby testing my concept that peer-professionalism explains most of the capabilities of the NEP. Sterile syringes can be distributed by state agencies, for instance in electronic vending machines. Such electronic syringe dispensers offer several benefits. They can be used by underage IDU with no questions asked, which helps somewhat to address the problem of the NEP services being excluded from schools. These dispensers can operate after-hours. They can provide impersonal services for those who, for whatever reason, either dislike the NEP premises or prefer impersonal interactions. Electronic dispensers, if used during working hours, provide a way of comparing the personalised outlet to a depersonalised alternative, from a client’s perspective.

Nevertheless, there are significant problems as well as benefits. Electronic dispensers are more expensive to maintain than has been generally budgeted for.⁵⁶⁸ From the perspective of some IDU, they are just a machine, to be vandalised when malfunctioning and not delivering the expected services. It seems likely that the IDU who are presumed to vandalise these machines are applying the same logics and practices that they do to interactions with the state and professional structures

567. “we must work closely with, rather than against, those groups that are at greater risk of acquiring and passing on AIDS” (Lange, 1987).

568. From such considerations it would seem that the logics of electronic dispensers need to follow the logics of syringes and their supply, in the same way that syringes need to follow the drugs supply networks to the sites of injecting. As with syringes, the costs of maintaining such technology needs to be low, the dispensers need to be constantly associated with a high level of peer presence and activity, and they need to not seem to compete with peer activity.

they consider impersonal or antagonistic. This leads to a supposition that such machines do not engender trust, nor other useful motivation changes, except by providing an undesired contrast with more welcomed aspects of peer-professionalism such as shared experiences and mutual respect.

A second consideration lies in the networking role of peers. Peers carry out informal outreach by circulating drug using and health information in domestic situations outside of the NEP's outlets. Yet the more the numbers of such peers decrease, the less outreach takes place. The electronic dispensers actually increase the harms if the ease of obtaining syringes after hours is countered by a decrease in the numbers of peers employed in the NEP. According to my analysis, technological solutions by themselves cannot adequately address problems of misplaced trust or inadequate motivation towards well-being. Electronic dispensers effectively compete with the logics of peer outreach and peer surveillance. The benefits of IDU accessing syringes and information at peer-professional exchanges seem as essential as in 1987.

Sometimes IDU provided information about syringes, and sometimes syringes have been the subjects that told stories about IDU as objects. In either account the circulations of IDU and syringes in and out of particular sites are encouraged to be regular and frequent, adding to the practicality and rigour of studies based on IDU with prison experience attending needle exchanges. The symmetry of syringes and IDU, where each can stand for the other in certain circumstances that become more likely within the hybrid parameters of the NEP, is seen to have emerged as part of a more general heterogeneous network environment.

There has only been one, singular, needle exchange programme in New Zealand. Notwithstanding this emergence of order from messiness, the developments were not simply driven by innate or essential properties of the actors nor by any properties of mutual alignment of needs. Instead, the developments were attracted and conditioned by mutual antagonisms that with work and sacrifices were persuaded into alignment. The developments were pulled by transient market processes and interests as much as pushed by deviant desires and health aspirations that would not go away. The NEP logics and mechanisms continue to be fuelled by the distrust of marginalised groups for health authorities that enforce systems of medicalising and criminalising the use of substances.⁵⁶⁹

3 A way of looking

I have shown how the NEP has followed the flow and eddy of the circulating syringes, while altering their meanings, by relying on peer engagement, applying harm reduction logics, supplying sterile syringes, and recovering used syringes. The NEP has achieved these goals through 'peer-

569. For example, in joint raids with police on party drug supply shops (Christchurch Press, 2007: A5) and in promoting the criminalisation of mild stimulants such as BZP and nitrous oxide.

professional' organisations and individuals working within and maintaining their niche environment. In this environment, the non-compliant motivations and illicit practices of IDU have 'counter-excluded' the presence of the established health professions in any type of peer engagement role. The NEP has become a durably exceptional addition to the institutional environment which it has itself been made necessary by, and through which it has been shaped. It has been an innovation, certainly, but in another sense it has been an echo of institutional pain that has reverberated and shifted frequency into greater organisational density and force. Peer-professionalism has overridden both harm and accusation in a celebratory ethics of resonance with pragmatic realism. Yet from any individual participant's experience and perspectives, there has seemed far less reason for celebration. For the alternatives cannot easily be felt or seen at an individualist scale and scope.

Although some peers will be motivated to pursue a peer-professional career, marginalised people do not necessarily speak with one voice. The NZAF's shifts towards corporate management and professionalism were accompanied by some distrust and resistance from the gay community networks which preferred the Shanti 'support model', or a gay rights activist model.⁵⁷⁰ These developments illustrate how problems emerge when professionalising strategies develop out of, then achieve, a degree of autonomy from community expectations. In this account, such problems emerge because the activity of hybrid systems relies on connectivity between personal, local, regional, and national scales of organisation. Differences of morality and motivation become apparent because the marginalised community differs from the corporate representation of such a community. Nor is a marginalised community likely to welcome the professionalisation of its members into expert specialists and lay 'incompetents', unless clearly evident net benefits are thereby gained.

IDU generally know of the NEP's logics and mechanisms through their everyday lives rather than through research reports that represent the application of a disciplined research imagination. These everyday IDU life stories and practices are a source of personal awareness, of local knowledge, and of a collective network of motivations that operate quite independently of research, and of research bias. Yet conventional social and policy research has seldom inquired from such sources how programmes and policy shifts have influenced IDU motivations. There is even less academic literature on the links between the harms and motivation effects of prison environments, of IDU attitudes to risk-taking, and of the impact of needle exchange programmes. Research methods that engage with IDU ownership of their own desires and needs, rather than opposing their interests by framing them as abnormal, inauthentic, or otherwise unhealthy, seem needed. These methods are needed to engage with the motivational aspects of boundary maintaining processes among

570. These internal conflicts led in 1990 to a breakaway by the Auckland regional branch. See Lindberg & McMorland (1996: 109), CASONZ (1990b).

situations involving injecting drug use, needle exchanges, health professional territory, and state agency governance.

Artistic sensibilities and goals, shaped by sociological skills and craft, seem also required for engaging with unique and complex issues. This ‘anti-purist’ approach to social science adds craft and art⁵⁷¹ to requirements for evidence and rigour of analysis. I think this because all the key informants in this research, when asked for explanations, have drawn attention to the NEP’s random aspects and unplanned developments. These might be considered narratively similar to inheriting a trait with unknown potentialities. Or one might consider how the hybrid metallurgy scripted into cast wootz steel and pattern-welded swords followed path-dependent trajectories that clustered alongside those of horse breeding, armour, aristocratic systems, diseases of warfare, infrastructures of land ownership, and hierarchal governance that feature in the histories of India and Japan.⁵⁷² Viewed historically, clusters of narratives make sense from the way events follow after detailed experiences, building or detracting from contingent incidents, in temporal flows or steps that are always in hindsight perspective or imagined from hindsight into future possibilities. A synchronic perspective, where a sectional description is cut across such clustered narratives as perceived at the time or recounted later, makes sense of the way conceptual categories and actual networks of things appear configured in systems of inclusions and exclusions. I used this contextual awareness of narratives, sequences, and shaped configurations in my analysis, where I followed the stages and movements of NEP interactants through complex historical and institutional systems.

When such familiar and different, such old and new configurations of boundary lines are perceived as intersecting, has a cause resulted in something being brought into being? Or did already existing things become more visible and more active through a distributed collective activity constructing a visualising effect whereby things which had been less visible as background become foregrounded? The first perspective, which focuses on the beginnings and ends of events, is more historical, the latter perspective, which focuses on reassembling componentry, is more interactional. I have worked with both perspectives because the path-dependency of historical events better accounts for the timing, while the interactional shapes better delineate the rearranged institutional positionings and material contingencies. Participants were motivated by narratives to draw on institutional alignments and oppositions in their methods of innovating, yet shaped and accounted for such innovations by means of a new consensus of narratives and regulations.

571. By art I refer to the objects, rituals, funding valuations and cultural mechanisms for reconfiguring or reinforcing sensibilities between individuals and wider institutions. Art valorises individual artists, curators, participants at showings, and owners of purchases. Its the opposite of impersonal and of institutional, which draws attention to the way corporate organisations display art pieces in foyers and offices, partly as trophies captured from the enemy, partly as a claim to a distinctive, individual corporate identity. And so art is never pure, nor should be expected as such, notwithstanding experiments in ‘pure technique’.

572. Refer Ch. 1 Section 3. See Untracht (1982: 364-365).

My analysis has drawn on a nomadic strategy of working with the material at hand as much as possible, rather than relying on references to postulated external structures that are represented as explaining events without cause, conditions, or mechanism of effect. In this nomadic perspective, whether termed actor-network or Deleuzian, or dharmic, or historical or an institutional type of analysis, I have attempted to ‘twist’ problems of complexity into patterns of productivity. I worked by following the difficulties, treating them as opportunities, and applying symmetrical methods of analysis that are not ‘neutral’, because they were locally embedded in the localities of the case and in my participant immersion as a researcher. In this twisting, as with a moebius strip, planar boundaries are overcome through iteration. By means of the twist, all planes become accessible through linear movements of narratives, evading the need to use separate categories and privilege their distinctions to preserve idealist logics. Despite this navigational argument against boundaries being in any way essential being itself located in an abstract plane, I draw attention to how my methods have been reliant on demonstrable indicators such as documented accounts, and even-handed in approach to grounded differences in the perspectives of participants.⁵⁷³ This perspective characterises a type of sociology. Whatever it may be termed,⁵⁷⁴ it might well be described as a criminal, nomadic, and critical sociology of co-dependent interactional materialism.

I have shown that the logics and practices of the established medical and drug treatment professions competed with those of the NEP. The NEP’s principles were accepted as effective and efficient, in a particular environment when no cures for a contagious disease existed, and where strong mutual distrust between IDU and professional health specialists made conventional prevention methods impossible or unaffordable. Yet if cures for HIV and HCV become more feasible than the prevention of transmission, or if greater trust developed between IDU and drug treatment specialists, then the key constituents of the NEP niche of interactivity would weaken.⁵⁷⁵ If there was a cure for AIDS there would be less need to maintain the trust of deviant communities, since members would be forced to comply with conventional health professions to be cured. If the NEP lost its hybrid productivity it would be more vulnerable to assimilation or subordination tactics by the professions that find its presence irritating. A wider environment of longer-term conflict between IDU and medical specialists, and between health professions and state agencies, has and will continue to influence the NEP.⁵⁷⁶

The influence of peers, in empowering IDU to supply safety for themselves and colleagues, has

573. This is like braiding a rope of on-going symmetrical twists as contrasted with tying a knot of asymmetrical closure. The NEP itself is more like an extended knot, or asymmetrically braided rope. By contrast, I have tried to treat the research methods as braiding a continuing rope, as smooth as possible, yet also adequately following the contours of the NEP.

574. mobile sociology?

575. The financial and dependency costs of curative interventions would seem to always exceed those of well co-ordinated prevention programmes and strategies in a stable, equitable society that actually provided health treatment.

576. Nonetheless the intensity of physiological technology and the commodification of embodied desires for reconfiguring identity, for feeling and becoming better, makes all predictions groundless, all singularities of identity suspect, like a “wave without a shore” (Cherryh, 1984).

worked as a network approach to a network problem. The NEP's opportunities and productivity emerged from a good fit between hybrid organisation and hybrid environment. Accordingly, the limits to expansion and change were also shaped by these factors, in a single mechanism of multiple interactions. In effect, IDU traded a degree of confidentiality for particular health benefits, as was formally proposed in 1988 (Read, 1988) by Dr. Baker, the founding architect of the NEP. In this process the peer employees gained social status and opportunities to represent IDU who, being illegal, could not publicly represent themselves without risking arrest or harassment. Governments and state agencies gained surveillance data on population demographics and practices, while reducing the public hazards of disease transmission. As a nomadic researcher I do not ask whether the changes in the NEP's development were 'appropriate', but I have outlined the contexts and criteria for evaluating whether these changes led to greater or lesser capabilities.

The NEP did not merely respond to the constraints and pressures of its institutional surroundings. It also modified its environment, both structurally and path-dependently, raising questions about how such agency became organised, distributed, and effective. The NEP formed work spaces (Hacking, 2002) where practices involving logics of risk and trust were induced to permeate and 'satisfy' unavoidably opposed interests. This is why the health and crime institutions that set up the NEP's environment and logics did not simply revert to business as normal, nor simply accept a new harm reduction regime by enacting appropriate legislation. In consequence, the NEP was offered an extended window of opportunity to commercialise, expand, and remain partially yet distinctly deviant. Due to fortunate circumstances, callous official neglect, and internal conflicts, such opportunities were taken up in dynamic rather than bureaucratic innovations, coming from the ground up and extending horizontally as well as from the top down.

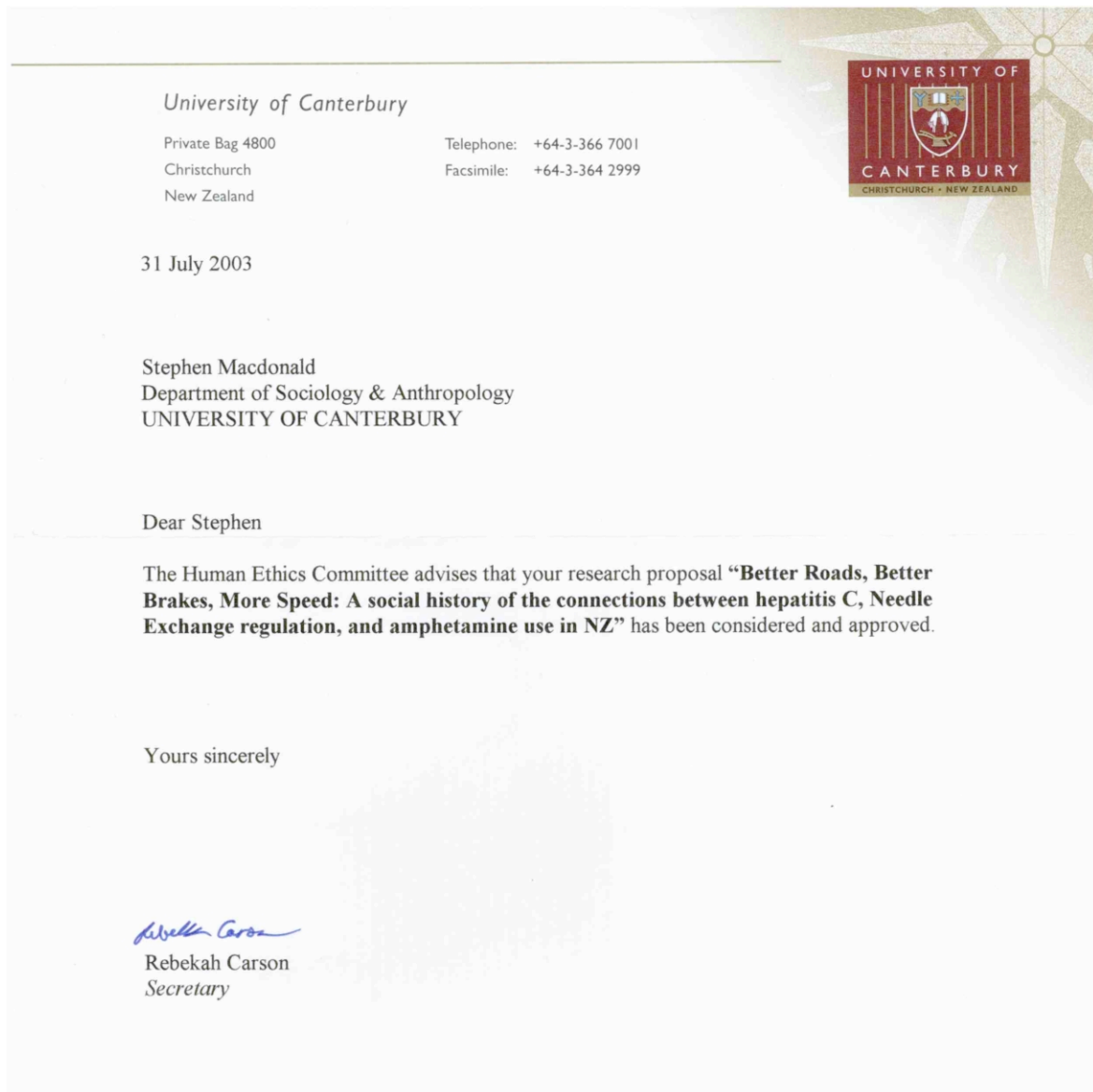
The NEP aligned with state policies of planning long-term benefits through population-based wellness methods, yet was introduced in urgency, was managed by default, and has been highly constrained by regulation and funding caps. Following a period of state sector fragmentation during the 1990s, the New Zealand government has attempted to re-integrate state agency infrastructures in a 'whole of government' project. Attention is accordingly drawn to the consequences of integration. Since an urgent and essential productivity has emerged from the hybrid antagonisms and fragmentation of needle exchanges, might over-simplistic integration cause significant harms as well as benefits?

As well as promoting a governance perspective that is long-term, evidence-based, and focused on outcomes, peer-professionalism has created specific problems for policies which criminalise and medicalise drug use. The NEP promotes a formal policy of neither condemning nor condoning illicit drug use (NENZ, 2005). Yet the NEP necessarily empowers drug users more as valid citizens, with legitimate health expectations, who rightfully exercise a public voice. Peer-


professionals who represent IDU effectively resist and reshape criminalising and medicalising processes, even while being partially state-subsidised. In this way the peer-professionals reduce inequalities and extend the scope of citizenship. Such a role is traditional for the professions in a western liberal society, at least in terms of the deviance attributed to class, religion, gender, sex practice, and racialised categories, provided that professional jurisdictions are not thereby diminished. In New Zealand, the professions have in general, after over a century of doing otherwise, ponderously supported the decriminalisation of practices that seem distinctly private and do not exploit others. For instance, no profession in 2007 publicly opposes recreational sex outside marriage, sex-work, and the complementing of religious marriage codes by secular marriage and civil-unions. Peer-professionalism is in accord with such wider professional tendencies that mediate between public and private, but barely touch on the NEP sites and practices.⁵⁷⁷

Health professionals, officials, and IDU all needed the NEP to professionalise, but within constraining boundaries. The occupational and geographical niche that emerged from its workability in practice was largely shaped by its 'potential' occupational population remaining relatively incapable, non-established, and non-threatening. By contrast, the jurisdictions of the full professions such as medicine and psychiatry were shaped from struggles among more established and capable occupational groups (Abbott, 1999, 1992a, 1988). As the NEP professionalised, with no occupational competition, its struggles to control its boundaries became focused towards the area of policy. By developing capabilities that partly competed with official systems and logics, the forms of deviance that specialised in illicit drugs, then as carriers of contagious diseases, co-produced and became overlaid with small and specialised forms of industrial action, made even more capable by a market monopoly over syringe exchange services. This occupational positioning from formal incompetence to acknowledged competencies has shaped the NEP's capabilities for sustainability and quality of care as becoming characteristically provisional, yet strangely fitting.

577. Safe sex supplies and educational materials are available at every peer group outlet as part of HIV/AIDS and general health promotion programmes.

1 Ethics Committee Consent

2 NEP Supplier Registration

DEPARTMENT OF  HEALTH

CHRISTCHURCH DISTRICT
RESERVE BANK BUILDING
158 HEREFORD STREET, CHRISTCHURCH

P.O. BOX 1475
CHRISTCHURCH
FAX (03) 799 125
TELEPHONE
799 480
FILE REFERENCE
14/6/3

DATE

TO 6 Sept 1989

Stephen Macdonald Luke
4/320 Madras Street
Christchurch 1

NEEDLE/SYRINGE EXCHANGE SCHEME

Your application for authority to supply new needles and syringes for non-therapeutic purposes under provisions of the Health (Needles and Syringes) Regulations 1987 has been approved.

Take notice that this authority may not be delegated to any other person.

A copy of the provision of these regulations is enclosed for your information.

District Co-ordinator Needle and Syringe pack supplier


D C Lewis - phone (03) 799 480 Salmond Smith Bio Lab
PO Box 1475 Biological Laboratories Division
CHRISTCHURCH Phone (09) 418 3039
Telex 21637
Fax (09) 418 0729

Collection Service - Canterbury


D C Lewis
Christchurch
Phone (03) 799 480

Local Answerphone Number NZ AIDS Foundation Hotline Number

Christchurch (03) 661 380 Auckland (09) 395 560 toll free


D C Lewis
Co-ordinator
Needle/Syringe Exchange Scheme
for Manager
Health Development Unit

enc

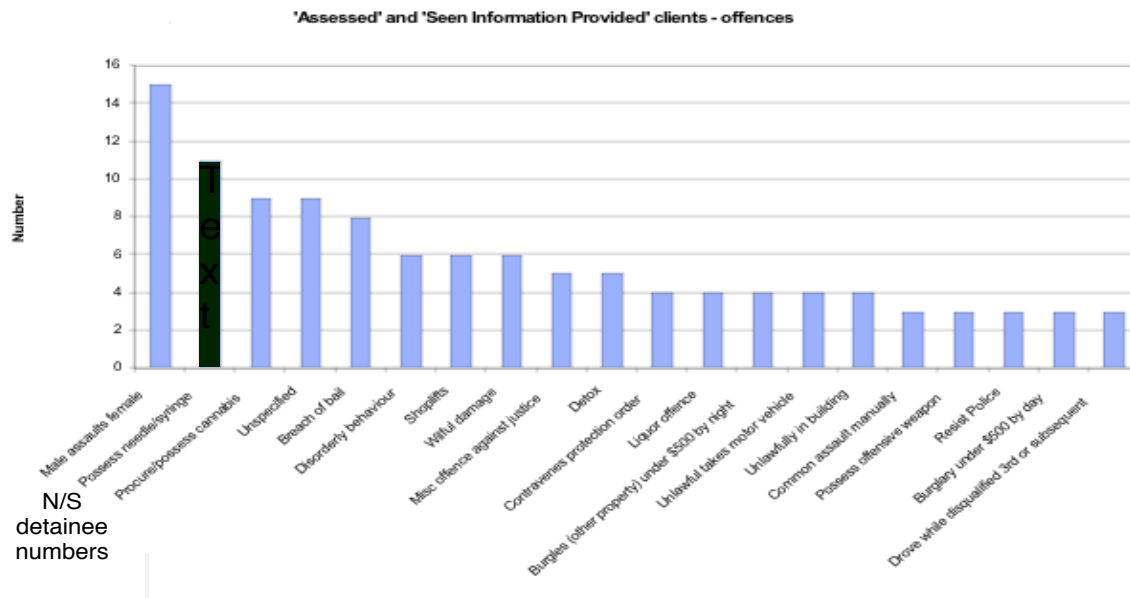
 HEALTH FOR ALL

WP15A:005

3 Arrest Referral Scheme Data: 2005

Chart 1: Arrests for syringes in 2004-5.

(from Arrest Referral Scheme, 2005: 3.)⁵⁷⁸



In this diagram the number of those arrested is on the vertical axis. The charges are laid out along the horizontal axis, seemingly in no particular order except the numbers being charged.


Key to Chart 1:

From left to right the charges consist of:

Male assaults female.	15
Possess needle/syringe	11
Procure/possess cannabis	9
Unspecified	9
Breach of bail	8
Disorderly behaviour	6
Shoplifts	6
Wilful damage	6
Misc. offence against justice	5
Detox	5
Contravenes protection order	4
Liquor offence	4
Burgles (other property) under \$500 by night	4

578. Bold 'N/S arrest data' caption inserted, and N/S arrest data column highlighted, for legibility.

Unlawful takes motor vehicle	4
Unlawfully in building	4
Common assault manually	3
Possess offensive weapon	3
Resist Police	3
Burglary under \$500 by day	3
Drove while disqualified 3rd or subsequent	3



BLOOD

Hepatitis C ... The neglected epidemic

- HCV is a blood-borne virus that affects the liver
- Some 3% of the global population live with HCV
- HCV will kill 4 times as many people as AIDS
- HCV can cause long term liver disease and is potentially fatal
- An estimated 35 000 New Zealanders currently live with the virus
- No vaccine ... no cure. ARE YOU AT RISK



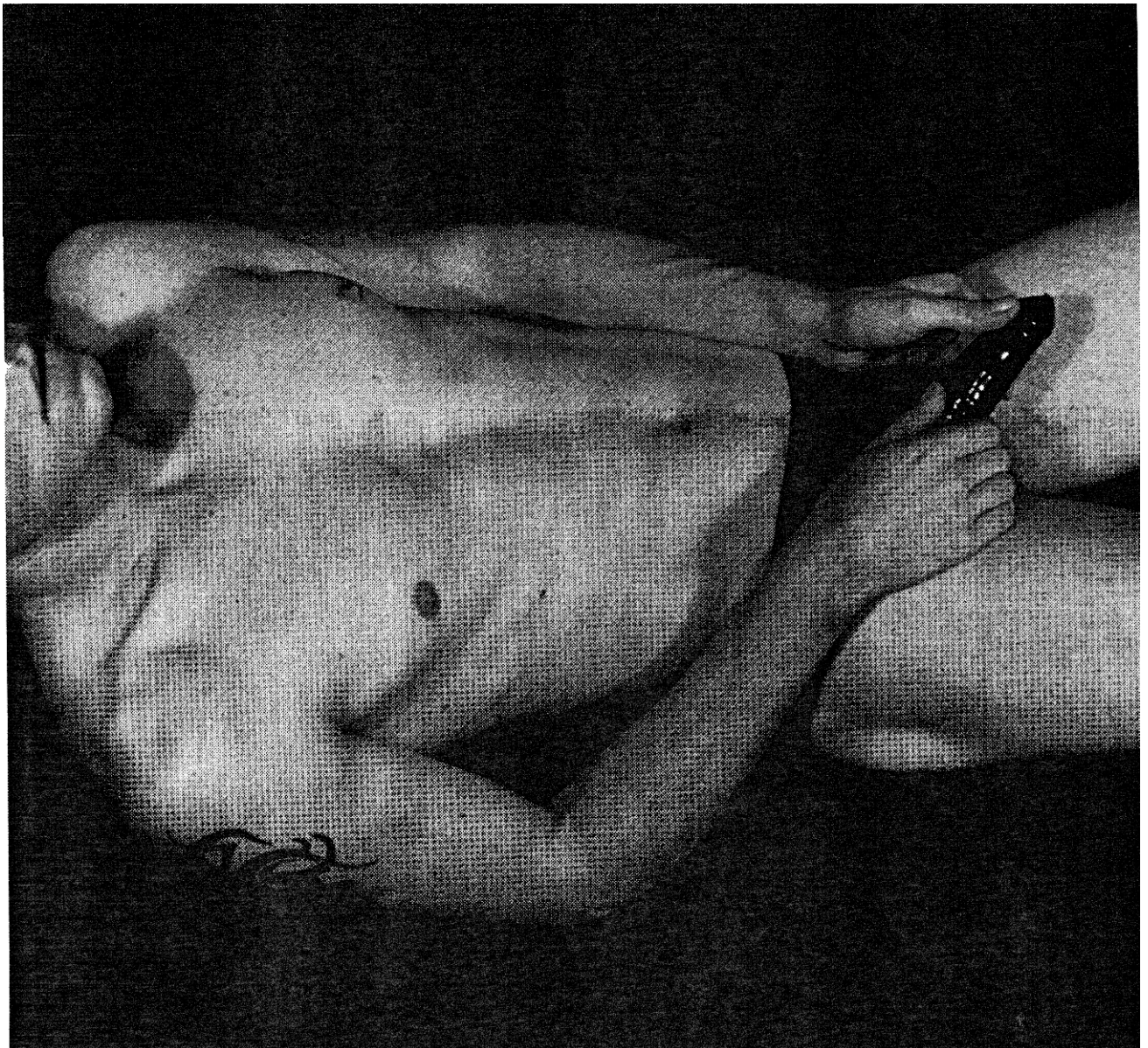
The Rodger Wright Centre
10 Liverpool St, P.O. Box 22-478,
Christchurch, NZ.
Voice: 03-365-2193 Fax: 03-365-2508
Email: rwc@xtra.co.nz

harm reduction services & hiv/aids
prevention programme



Hepatitis C Services, Te Waipounamu
Suite 83 / 224 Cashel Street, Christchurch
Phone (03) 366 3608 Fax (03) 366 0649
Email: hcv@xtra.co.nz





RUBBER

- Condoms are the best protection from HIV / AIDS and Sexually Transmitted Infections
- Do you know your partners' history?
- Don't let the heat of the moment dictate
- Insist he uses it, every time - No exceptions!



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10 Liverpool St, P.O. Box 22-478,
Christchurch, NZ.
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harm reduction services & hiv/aids
prevention programme





CLEAN

- IV drug use is the most effective method of transmitting HIV / AIDS and Hepatitis B+C
- Don't share your needle, syringe, or works (spoons, tourniquets, bench-tops, filters, water)
- Use a new fit every time
- Get informed! All the info you need is at your local Needle Exchange
- Filter your future (use a wheel filter for every hit)
- Use sterile H₂O or water that's been boiled for 20 minutes
- Swab before injecting
- Return used fits to a Needle Exchange for destruction



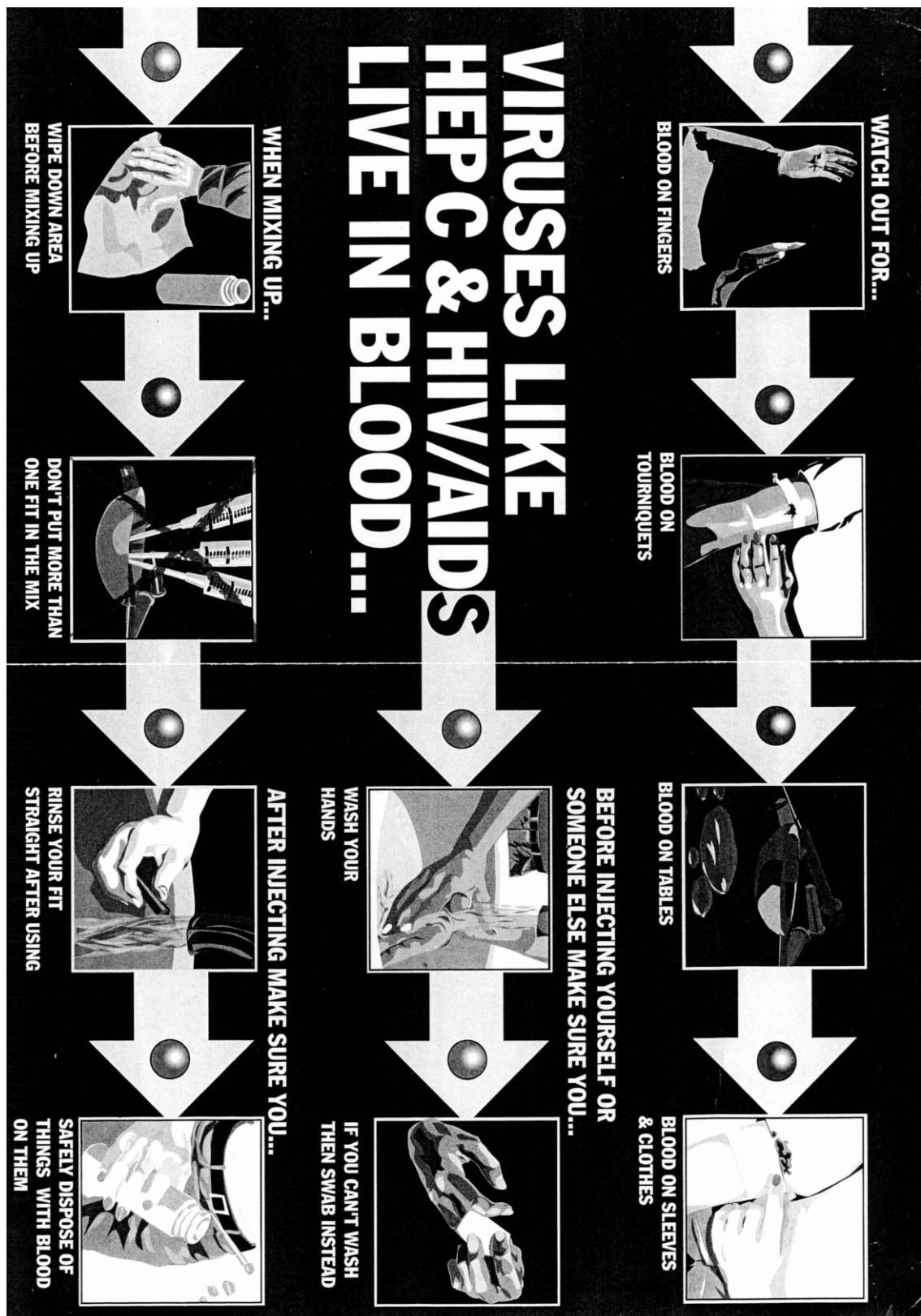
CROWN
PUBLIC
HEALTH

The Rodger Wright Centre
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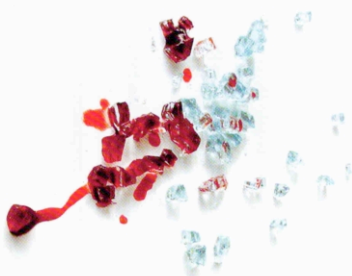


Drug
Injecting
Service in
Canterbury
Trust

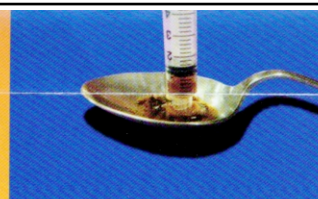


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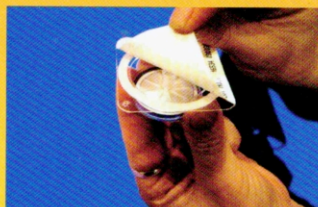
Safer Injecting

BE BLOOD CAREFUL.**Use a new fit for every hit****BE BLOOD CAREFUL.****In the sports blood bin****BE BLOOD CAREFUL.****Use gloves when wiping blood**

1. Draw up drugs through clean cigarette filter or cotton wool into a new mixing fit.



2. Peel back the cover from the wheel filter package.



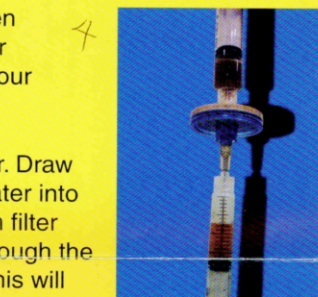
3. Carefully screw mixing fit onto wheel filter (not too tight).



4. Screw a new needle onto the wheel filter outlet. (don't touch the filter outlet)



5. Using gentle even pressure push gear through filter into your new fit(s).



6. Remove the filter. Draw up a little sterile water into mixing fit. Re-attach filter and push water through the filter into your fit. This will get any remaining drugs out.



7. Screw a new needle on to your fit, and it's done.

If you need more than one wheel filter for the job, either use 2 mixing fits, or you can piggy back the filters like this. Make sure you put the finest filter at the end.



Hepatitis C Health Information Leaflet

Information you should know about hepatitis C

- Hepatitis C was first officially identified in 1989 but it could have been in N.Z. as far back as the 1950's.
- One in every hundred adults in New Zealand lives with the virus. Researchers believe that as many as half of those infected remain undiagnosed.
- Seventy-five percent (75%) of those infected with it will become chronically infected. It is a blood borne virus that may cause liver disease in approximately 60% of those chronically infected.
- There is no vaccine to prevent infection and there is no universal cure.
- Up to 20% of those chronically infected will develop cirrhosis of the liver after 25 years. This may progress to End Stage Liver Disease or Cancer.
- Most people infected with the virus will not experience symptoms for 15 years. If symptoms do occur they are often too general and unspecific to suggest hepatitis C.
- A person with hepatitis C often has 'bouts' of symptoms that come and go. Persistent illness and the uncertainty of one's health in the future greatly diminish their quality of life.
- The vast majority of those infected with it will not die from it, but health costs burdening the person, their families and the community will gradually increase as the years go by.
- Current treatments are expensive, not easily tolerated and on average are successful for only 60% of those treated. The number of people taking up the treatment remains low.
- There are likely 25-35 new infections every week. At least 90% of these result from people sharing equipment to inject drugs. The highest risk group is young people between the ages of 16-25.

It is more of a problem than you might think!

Risk Assessment

Life Style

Currently, or in the past, have you:

- Been exposed to improperly sterilized equipment while having a tattoo, body piercing or acupuncture?
- Snorted drugs from a shared straw?
- Injected IV drugs (even once)?
- Shared a razor, toothbrush, or any item that could carry infected blood?
- Been in prison?
- Been in the military, particularly on overseas duty?
- Had casual unprotected sex with multiple partners?
- Lived intimately with someone who would fit any of the above descriptions?

Work History

Has your work ever put you in contact with blood, blood products or needles?

Examples include:

- Health services: Doctors, Nurses, Dentists or Dental Workers, Oral Surgeons, Hospital Cleaning Staff
- Armed Forces
- Emergency Services: Ambulance Drivers, Police Officers, Firefighters, Paramedics
- Prison Staff
- Laboratory technicians (Science and Clinical)
- Tattooists, Piercers and Beauticians
- Institution workers

Medical History

Currently, or in the past have you experienced any of the following:

- Blood transfusion, (or received blood products) before July 1992.
- Abnormal liver functions.
- Haemodialysis treatment.
- Chronic fatigue (without explanation).
- Any surgery, including oral surgery or c-section, where blood or blood products have been administered.
- Diagnosed as HIV positive, or as hepatitis B or hepatitis C antibody positive.

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Why should I wash my hands??

Hand washing is the single most important procedure in preventing infections. Some germs can stay alive on our hands for up to three hours and in that time they can be spread to all the things we touch. Think about all of the things that you touched today - from the telephone to the toilet. Maybe you blew your nose in a tissue and then went outside to dig around the dirt or patted the dog. Whatever you did today, you came into contact with germs. - This is why it's important to wash your hands regularly throughout the day and especially when you are going to be injecting!!! Unwashed hands before a shot could result in bacteria from your fingers and hands being transmitted to mixing & injecting equipment and possibly into your shot. Once bacteria have entered under the skin they may multiply in the moist, airless environment and cause such problems as abscesses, cellulitis, endocarditis or even septicemia.

How to Wash Hands

We all think we know how to wash our hands but many of us don't do it properly.

Simply rinsing the tips of fingertips under cold water does NOT count. Here are some reminders:

- Always use warm water with soap (warm water helps break down oils on the skin better than cold)
- Rub hands together vigorously for about 20 seconds, making sure both sides of the hands are washed thoroughly, around the thumbs, between each finger and around and under the nails.
- Then, rinse with clean water.
- Germs spread more easily if hands are wet so dry them thoroughly. Use a clean dry towel, paper towel or air dryer; it doesn't matter which.

Did You Know?

♥The number of germs on fingertips doubles after using the toilet. Yet up to half of all men and a quarter of women fail to wash their hands after they've been to the toilet!

♥1,000 times as many germs spread from damp hands than dry hands.

♥If you wear a ring there could be as many germs under it as there are people in Europe. Millions of germs can also hide under watches and bracelets.

How often should I wash my hands?

Hands should be washed often -- more frequently than most people do. Because bacteria and other germs cannot be seen with the naked eye, they can be anywhere!!

WHEN INJECTING HANDS SHOULD BE WASHED

Before: you clean your mixing area

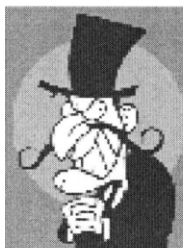
After: you clean your mixing area

Before: you mix your drugs

Before : you handle any sterile injecting equipment & your ciggy filter

Before : you help someone shoot up.

After : your shot.



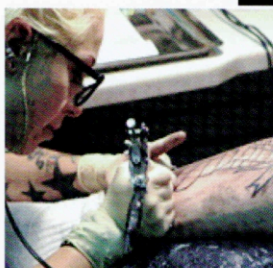
Don't underestimate the power of hand washing!!

The few seconds you spend at the sink could save you trips to the doctor's office.

-----Angee-----

BEST HYGIENIC PRACTICES FOR TATTOOISTS

For protecting the health of you and your clients



People working in the tattoo industry, and their clients are potentially at risk of contracting a range of diseases that may lead to serious illness and death if prescribed infection control procedures are not strictly adhered to. Blood borne infection such as HIV, hepatitis B & C, and a range of bacterial infections can be transmitted by using unclean equipment or working within unhygienic settings with sloppy procedures.

Most common infections:

Hepatitis C

A blood borne virus that can be transmitted by blood that may be left on needles used in tattooing procedures. Fifty percent of infections will lead to chronic liver disease, which in some cases may advance to cirrhosis of the liver, end stage liver disease and cancer. There is no universal cure for hepatitis C and no preventive vaccine.

Hepatitis B

A virus that is transmitted via blood and other body fluids. It can be sexually transmitted. Most people will clear this virus within six months of infection during the acute period, however, only a small number of those infected will experience acute symptoms. In rare cases, infection can result in the infected person becoming a long term carrier. Most people who become "carriers" will not become ill with it, but they do remain infectious to others and must monitor their liver health over their lifetime. Those that sustain liver damage are at risk of developing cirrhosis and liver cancer. There is a safe, effective vaccine and a course of three injections will provide protection to most people. A blood test is required to determine whether a person is protected.

HIV

Human Immunodeficiency Virus (HIV) is the virus that can cause AIDS. It can be transmitted via blood contaminating tattooing needles. It is also spread through unprotective sex. Currently,

there is no vaccine against HIV/AIDS and no cure. Safe and hygienic practices are the best prevention.

Bacterial infections

Common bacteria such as *Staphylococcus* can cause infections from unhygienic practices and result in septic skin infections, wound breakdown and possibly a ruined tattoo site.

How transmissions occur:

Needles and sharp instruments, which are used to penetrate the skin, may become contaminated with infected blood, and unless they are thoroughly cleaned and sterilized can pass disease from client to client, or to workers who might accidentally stick themselves with a contaminated item. Viral and bacterial infections (such as *Staphylococcus*) can happen when infected instruments penetrated the skin or come in contact with mucous membranes.

Other factors which may contribute to infections:

- When material that clients are in contact with are not cleaned or are not handled or used hygienically.
- When the tattooist does not keep themselves or their premises clean and hygienic.
- When the premises, including furnishings and fixtures are not kept clean and in good repair.
- When disinfection/sterilization practices and equipment are inadequate (i.e. unmonitored autoclaves - apply spore test).

HYGIENIC & HEALTHY TATTOOING ~ BASIC STEPS

Preparation of the work area

- Ensure the work area is clean and tidy.
- Set up work area making sure all items required for skin preparation, tattooing, skin dressing and waste disposal are within easy reach.
- Cover any work surfaces in the immediate area with disposable coverings - one per client.
- Cover surfaces which may need to be touched eg. Spray bottles, power controls & telephone, with a plastic barrier.
- Always wear clean clothing including shirt/t-shirt, pants and shoes.

Additional work area items

(preferably in the presence of clients)

- Dispense the required pigment, lubricating jelly, therapeutic cream and any other lotion required into a single-use disposable container using single use spatulas. Single use spatulas should always be used when handling the petroleum jelly or any cream or lotion
- Place water to be used for rinsing between colours into a single-use disposable cup
- Place sufficient single-use wipes for one client in the area
- Remove rings and thoroughly wash hands using soap or detergent under running water. Dry hands using a single-use paper drier or air dryer
- Wear clean new disposable gloves for each client



Skin preparation

- Ensure that the client's skin around the tattoo site is clean and free from sores or infections.
- When shaving the area, use a new disposable safety razor for each client.
- Disinfect the skin around the tattoo site using either a single-use alcohol swab or a single-use wipe with skin disinfectant which (a) has been decanted into a single-use container or (b) is applied with a spray bottle. This bottled must be emptied, cleaned and refilled daily and must never be topped up.
- Leave the disinfectant of alcohol swab on the skin for at least two minutes before starting skin penetration.
- Prior to the placement of the stencil, an antiseptic lotion (i.e. Dettol™) may be applied to the tattoo site using the methods outlined above.
- Because of the high risk of cross-contamination with blood, only single-use stencils should be used to mark the skin.
- Apply lubricating jelly to the tattoo site using a clean, new single-use spatula for each client. Never use gloves or bare fingers to apply lubricating jelly. Always discard spatula after each application.

Prior to tattooing

- Open autoclave bags containing tubes and needles attached to needle bars, and check indicator colour. If satisfactory, then assemble hand piece. N.B. Proper validation of steam-sterilization is a complex issue outside the scope of this document.
- Inspect all needles for defects. Never test them for sharpness on a operator's skin.

HYGIENIC & HEALTHY TATTOOING ~ BASIC STEPS

Tattooing

- Wash hands or use alcohol based sanitiser before putting on the gloves, use new disposable gloves before starting a new tattoo.
- Always wear new disposable gloves on both hands for each client and wear throughout the tattooing procedure. If other surfaces (i.e. lamp) are touched during the procedure the tattooist should re-glove with a new pair.
- Tattoo outline of the design.
- Change needle assembly or hand piece taking care not to cross-contaminate machine or clipcord, use bags or change gloves.
- Tattoo the colour or the shade of the outline.
- As far as possible avoid contamination of work area with the client's blood.
- Avoid cross-contamination between surfaces eg. Whilst tattooing, do not eat, drink or smoke. When leaving clients during the tattoo procedure, tattooists should remove and dispose of their gloves, and thoroughly wash their hands. If the client takes a break during the process then cover the skin being tattooed with a dry clean dressing.
- After any breaks during a tattoo (eg. Answering the phone, toilet break), wash hands and put on new disposable gloves before resuming tattooing
- During tattooing, use a cleaning solution from a spray bottle and a disposable wipe to remove excess pigment and blood from the tattoo site (never spray directly on tattoo-risk of airborne contaminants).
- Control any excess bleeding by applying pressure to the wound with a dry sterile dressing
- During and after bleeding, handle contaminated instruments and dressings carefully to avoid contact with blood.
- Dismantle, ultrasonically clean tubes, rinse in warm water, scrub crevices and grooves and autoclave any contaminated instruments.
- Wash contaminated surfaces such as benches, chairs and floors with mediwipe surface disinfectant.
- Thoroughly wash hands after removing gloves.
- Dispose of contaminated materials in a 'contaminated waste container' or a 'sharps safe' container.

After tattooing

- Remove therapeutic cream from a single-use container (if not available use fresh gloves) and apply to the treated area by means of a single-use spatula, and cover with a sterile dressing.
- Take time to tell and show the client how to care for their tattoo to prevent infection and provide the client the same advice in writing.
- Dismantle the needle assembly and place disposable needles into a 'sharps safe' container for disposal.
- Ultrasonically clean tubes.
- Remove and discard disposable gloves.
- Wash hands after tattooing and cleaning the work site.
- Clear the work area.

Cleaning, disinfection and sterilization

(in separate cleaning area and wearing heavy duty gloves)

Electrical hand piece

- Clean with cotton wool or a cotton pad saturated with 70% w/w ethyl alcohol or alcohol wipes.
- Allow to dry naturally.
- Store in a clean, impervious, covered container.

Benches, chairs and other work surfaces

- Wash with soapy water, rinse with clean water and dry with a clean disposable wipe.

Instruments including needles, needle bars, tubes and nozzles

- Rinse in warm water taking care to prevent any needle stick injury or splashing.
- In a sink, immerse instruments in warm water and detergent, then hold the instrument under the water and scrub with a clean brush.
- Rinse clean instruments in warm water and dry using a lint-free disposable towel.
- Place cleaned instruments in an autoclave bag and sterilize in a bench-top autoclave which complies with Australian Standards AS 2182:1994.



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HYGIENIC & HEALTHY TATTOOING ~ BASIC STEPS

Effective sterilisation depends on three factors:

1. *Cleanliness – the articles to be sterilised must be thoroughly pre-cleaned to allow good contact to all surfaces during the sterilisation process.*
2. *Temperature – the correct temperature must be reached and maintained for all the articles being sterilised.*
3. *Time – the sterilisation temperature must be maintained for the correct period of time.*

Garments and other washable fabrics

- Wash with detergent in water.
- Rinse and dry (alternatively have commercially laundered).
- Store in a clean, appropriate area such as a closed cupboard.

At the end of the day (and after every procedure)

- Clean the hand basins, sinks and floors with a hard surface disinfectant or bleach in warm water.
- Dispose of all potentially contaminated, used materials in an appropriate 'sharps safe' container for collection & destruction through an appropriately licensed & regulatory compliant organisation eg. Needle Exchange Services Trust, ph: 03 366 9403.
- **TREAT ALL USED EQUIPMENT AS POTENTIALLY INFECTIOUS.**
- Ensure the autoclave is maintained according to the manufacturers instructions.
- Wash hands after cleaning is complete.

Staff safety

- Consider and discuss hepatitis B immunisation for you and your staff.
- Ensure that any breaks in your skin or that of your staff are covered with a waterproof bandage that will completely protect the wound.
- Assume that everyone's blood is potentially infectious and treat everyone the same way by infectious disease procedures.
- Consult your medical practitioner if you or your staff sustain a needle-stick injury.
- The local Medical Officer of Health would have to be notified and a needle-stick accident report completed. OSH would also have to be contacted.



Primary prevention of infectious diseases like hepatitis B, C and HIV requires that procedures around blood and body fluids are safe and maintained by everyone in the workplace. It is in the best interest of all, tattooist/operator, staff and clients that your practices do not lead to the transmission of infections.

Although it may be difficult to prove, anyone who has picked up an infectious disease after having work done in your parlour could potentially ruin your business by taking action against you. It is your legal obligation and an OSH requirement to ensure that your workplace is safe and hygienic for employees and clients, and that staff are given every opportunity to learn and practice proper infection control procedures.

To obtain further guidelines set out for the tattooing and piercing industry in New Zealand refer to "Guidelines for the Safe Piercing of Skin", Ministry of Health (Safety and Regulation Branch) 1998.

This pamphlet has been produced in collaboration between the Hepatitis C Resource Centre and the National Office of the Needle Exchange Programme as a quick reference guide for people in the tattooing industry. We are primarily funded by the Ministry of Health.

To contact the Hepatitis C Resource Centre we are at: Level 2 Gough House, 90 Hereford Street, Christchurch. Phone: **0800 22 4372**

Also check these websites for further info: www.hepc.co.nz and www.needle.co.nz

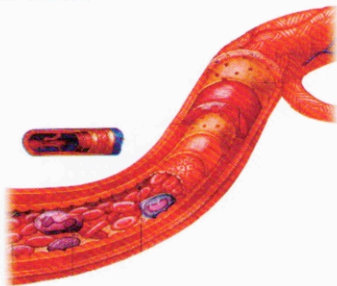
- References: ■ Guidelines for the Safe piercing of Skin-Safety and regulation branch, Ministry fo Health 1998.
- Commonwealth Department of Health and Aged Care: Hygienic Proceedures for Tattooists- protecting the health of yourself and your clients, PN2112.

physiological-technological information about injecting



Let's face it- injecting drugs is dangerous.

However, you can reduce the danger and look after your veins by improving injecting techniques. There is no sure way of making injecting safe for your veins, but there are ways to reduce vein damage. Learn to look after your veins- after all you do get ONLY ONE SET.



WHAT YOU SHOULD KNOW:

- The correct needle gauge and syringe size to use
- What veins are suitable to use
- How to filter your drugs
- How to use a tourniquet correctly
- How to insert the needle correctly
- How to put your shot away slowly
- That acidity in shots is harmful to your veins.

The smaller the needle you use the less damage you cause your veins.
What gauge, (size), of needle you use depends on exactly WHERE and WHAT drugs you are shooting up.



If you are using your femoral vein you will need to use a smaller gauge and longer needle than if using your arms or hands. Any gauge over 27g is designed for intramuscular NOT intravenous use. The bigger the gauge, the bigger the hole at the injection site leaving the body more open to infections. So, when deciding what syringe is best for you, take your time, think about what drugs you are using, where you are injecting and most of all don't be afraid to ask for advice at any of the Needle Exchanges.

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Veintenance

WHERE TO INJECT:

ARMS: The least dangerous place to inject is your arm. Because inside your elbow there is a main vein.



LEGS: Circulation in the legs may be poor, especially if you are not an active person. Veins in the legs are much more likely to develop clots which could break off and lodge in your lungs or heart. Damaging veins in your legs is more serious as they play an important role in getting blood back to the heart. Always remember to keep leg elevated for at least 5 minutes while, and after injecting. Even if bleeding has stopped, this will help prevent "blowup".



NECK: The jugular vein is the riskiest place to inject because it lies so close to the carotoid artery, a major blood vessel that pumps blood directly to the brain. Accidentally hitting this could be fatal and damaging the jugular vein can interfere with blood circulation to the brain.



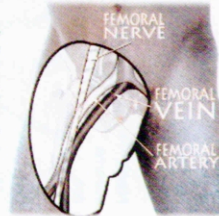
FEET: The veins in your feet are small and close to nerves, cartilage and tendons which you definitely want to avoid when injecting. Because the veins are further away from your heart, the blood circulates more slowly meaning they take time to heal. If you are using your feet give them a good scrub. Make sure wherever you inject is as clean as it possibly can be. Remember it is always good to use an alcohol swab before you inject even if you have had a good wash.

HANDS: are less safe than arms because the veins are much smaller and delicate. They bruise easier and because the circulation in your hands is slower, they take more time to heal. Your hands and fingers may become puffy and swollen if you have been using your hands for a reasonable length of time.

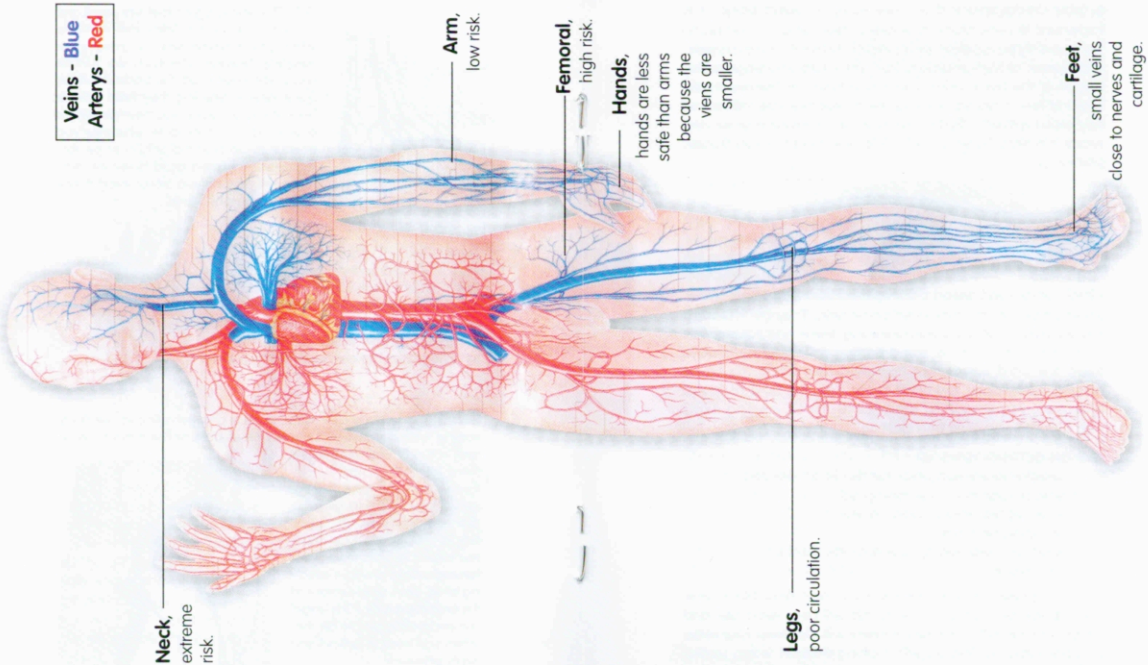


GROIN: The femoral vein in the groin is a large vein and relatively easy to locate. However, because it is so close to the femoral nerve and artery it is a **VERY RISKY** place to inject.

If you must inject here, find the pulse (artery) then move a short distance towards the inside of your leg to find the vein. You will not be able to see your femoral vein and will be injecting blind. Look at the colour of the blood carefully, if it is bright red and frothy, you've hit the artery and need to pull out and apply pressure immediately.

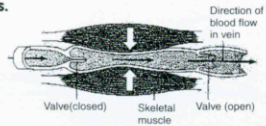


Veins - Blue
Arterys - Red



Veintenance

BLOOD CIRCULATION: If you are going to inject drugs, it is important to understand how blood flows around your body. There are three types of blood vessel: Arteries, carry oxygenated blood, at high pressure, from the heart and lungs to the tissues of the body. Veins, carry blood back to the heart and lungs at low pressure. Joining them together are millions of tiny blood vessels called Capillaries that transfer oxygen and waste products between cells and blood in the body tissues and lungs.



VEINS: Veins carry blood back to the heart and lungs at reduced pressure and they need some help. They get this from the movement of muscles squeezing them and forcing the blood along. To stop the blood getting squeezed both ways there are small valves that flap shut, preventing the blood flowing backwards. You must inject with the flow of blood otherwise, you force fluid against the valves, causing extra vein damage, swelling and clotting.

TIPS ON GETTING VEINS UP:

- Using a warm compress for five or 10 minutes, wheat bags are especially good
- Soaking the area in warm water
- Pumping your fist
- Swinging your limbs, increases circulation
- Wrist curls

Put a compress in the microwave for a short time. Place over the site you are going to inject, this will help veins rise and become more visible. A warm shower will also help your veins become easier to find, as will soaking them in warm water. Make sure the water is not too hot. Squeezing a tennis ball or exercising increases blood circulation.

TOURNIQUETS

Your tourniquet should stretch so that when pulled tightly it doesn't damage the skin and is easy to release once you have hit a vein. So, don't pull your tourniquet too tight, and **ALWAYS** release your tourniquet before you put your shot away. Damage can be caused from drugs not being able to enter the blood stream if your tourniquet is applied too tightly. So, put your tourniquet on, pump the muscle to get the vein up, and then swab the area you are going to inject with an alcohol swab.



INSERTING THE NEEDLE

Having found a safe site for injecting, insert the needle into the skin parallel to the vein, with the tip pointing in the same direction as the blood flow. Take care not to push the needle through the back wall of the vein. You are usually in a vein when dark red blood jacks back into the syringe. Release the tourniquet and slowly put your shot away. When the plunger hits the end of the barrel all the drugs are out of the syringe. Jacking blood back into the syringe and putting it back into the vein does nothing but cause extra damage to your veins.



GOOD THINGS TO REMEMBER ARE:

- The **SMALLER** the needle gauge the **BIGGER** the hole (a 22g leaves a much bigger hole than a 26g)
- You should always try to prevent injecting in the same place. Even a few millimetres may make a difference, giving your veins a chance to heal and stop them collapsing. Try injecting with both hands, this will be a handy skill to know when that old faithful vein won't come to the party. It is better to learn this skill sooner than later. **ONCE YOUR VEINS HAVE COLLAPSED, THEY DO NOT COME BACK!**
- Citric acid is less damaging to your veins than vinegar or lemon juice. Lemon juice can be particularly bad if it is old and can even make you go blind. The more diluted your shot the better it is for your veins and remember even if you are feeling sick put your shot away slowly. Take time to check the colour of the blood, if you do make the mistake of hitting an artery putting it away slowly gives you the chance to pull out and start again. This is better than the alternative, not realising you've hit the artery until you pull out.
- Always use a wheel filter. Depending on the drugs you are using it may be necessary to use more than one. Ask your local exchange staff what filter to use with the drugs you are injecting.

LET'S FACE IT: Injecting drugs, maybe the fastest way of delivering a drug into your system opposed, to smoking, snorting or oral administration. So if you choose to inject drugs, remember it is dangerous. This guide aims to make injecting safer. Remember that taking proper care of veins like your arms will prevent you having to move to more dangerous sites like fingers, groin or neck. Remember your local needle exchange is always willing to help with advice. We do not judge, we only aim to keep you healthy in your chosen lifestyle.

YOU SHOULD NOT:

- use a vein that is red and inflamed or has hardened.
- inject in your penis.
- inject temazepam, (footballs).
- inject into an artery.
- reuse, or share equipment.
- inject with tourniquet unreleased.



This injury was a result of injecting Temazepam (footballs).

YOU SHOULD:

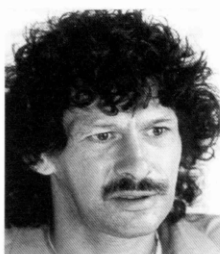
- always filter your drugs.
- always swab the injection site before injecting.
- check you are in a vein, not an artery.
- always put your injection away slowly.
- always apply pressure to site after injecting.
- always apply healing cream to immediate area not puncture mark.

Combined Agency Description and Health Promotion Pamphlet

 <p>RODGER WRIGHT CENTRE</p> <p><u>CITY:</u> 181A Hereford Street Ph: 03 3652293 Fax: 03 3652508 Email: rwcc@xtra.co.nz Website: www.rwc.org.nz</p> <p><u>HOURS:</u> Monday to Friday 9am to 10pm Saturday 11am to 10pm Sunday 12pm to 10pm Public Holidays 12pm to 8pm *****</p> <p><u>NEW BRIGHTON:</u> 108 Seaview Road Ph: 03 3880726 Fax: 03 3880727 Email: rwcc@xtra.co.nz Website: www.rwc.org.nz</p> <p><u>HOURS:</u> Monday to Friday 10am to 7pm Public holidays & weekends - closed.</p> 	 <p>THE RODGER WRIGHT CENTRE</p>  
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**He Aha Te Mea Nui O Te Ao?
He Takata, He Takata, He Takata**

**What is the greatest gift in the world?
It is people, it is people, it is people**



Rodger Wright was a key figure in the fight to have access to needles and syringes decriminalised. He sat on the National Council on AIDS, voicing the needs of people who inject drugs. At a time when it took exceptional courage to do so, he declared himself to be HIV positive, an injecting drug user, and homosexual. Rodger died in 1993. This Centre is dedicated to his memory.

It has been documented that needle exchanges do not cause an increase in drug use and save millions of dollars in health care costs each year. The Needle Exchange Programme's (NEP) primary objective is to stop the spread of blood borne viruses- HIV/AIDS and Hepatitis C & B, and to help break down the barriers for IDU's in the community. The Rodger Wright Centre's service is based on a peer service model, which means you will find staff with empathy & understanding about all drug use issues.

Over 80% of national distribution is via a peer service.

The Rodger Wright Centre is based on a philosophy of harm reduction rather than abstinence relating to drug use

SERVICES PROVIDED AT THE RODGER WRIGHT CENTRE CONT...

► ELECTRONIC DISPENSING MACHINE

Situated outside shop, 24 hour access to harm reduction kits (needles & syringes and condoms & lube)

► 24 HOUR USED NEEDLE RETURN

Chute situated outside shop giving 24 hour access to return used syringes & needles safely

► WEST COAST SERVICE

Once a month run to the West Coast delivering harm reduction kits.

► CLEAN UP KITS

Information on safe handling and disposal of discarded needles & syringes in the community

► SAFE COLLECTION OF DISCARDED USED NEEDLES & SYRINGES

The Rodger Wright Centre provides a service for the safe collection of used discarded needles & syringes in public places & private residences.

► MAINLINE MAGAZINE

3 monthly magazine articles and news for IDU's.

► VOLUNTEER TEAM

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THINGS YOU NEED TO KNOW

► The sharing of needles and syringes and injecting equipment is one of the most effective methods of transmitting HIV/AIDS and Hepatitis C.

- 1 out of every 100 people in NZ have Hepatitis C
- Having sex with no protection puts you at risk of HIV/AIDS and STI's (sexually transmitted infections)

THE RODGER WRIGHT CENTRE PROMOTES:-

BE BLOOD CAREFUL

- Always use a new needle & syringe for every shot and NEVER share needles, syringes, swabs, spoons, tourniquets, filters.
- Never share razors, toothbrushes, tweezers, face-cloths, body jewellery, or straws for snorting
- Wash your hands before and after every shot.
- Filter your future - use a wheel filter; an un-filtered shot can possibly lead to a dirty taste, abscesses, cellulitis (serious bacterial infection of the skin), endocarditis (infection of the heart valves), organ damage, blood poisoning & chronic infections that lower the state of your health & immune system.
- Always practice safe sex- use a condom (or a dental dam)

► If you think you might have been exposed to someone else's blood or you think you might be at risk you can contact the following places for support

**Rodger Wright Centre
03-3652293**

**The Hepatitis Resource Centre
03-3663608 or 0800 22 hepc.**

**AIDS Foundation
03-3791953**

SERVICES PROVIDED AT THE RODGER WRIGHT CENTRE

Friendly non-judgemental staff offer a confidential service that includes:-

► NEEDLE EXCHANGE

Shop open 365 days of the year, providing sterile injecting equipment, harm reduction information & body piercing equipment, safe sex supplies, advice, referral & resources.

► 1-4-1

Return any size needle & syringe in shop hours & get a 3ml & any size needle free.

► UP TO DATE INFORMATION

On drugs, harm reduction, sexual health, HIV/AIDS & Hepatitis C & B

► SUPPORT

For people injecting drugs, their family and friends.

► REFERRAL

► ADVICE

► WORKSHOPS

► PEER EDUCATION

Fully trained peer educators give educational sessions on NZ drug culture, various drugs & their effects, injecting equipment, Hepatitis C, B & HIV/AIDS, harm reduction relating to drug use, to individuals and the community.

► OUTREACH

Provides support, advice, referrals, information on drugs, Hepatitis C, B & HIV/AIDS & sexual health to the community who can't access a Needle Exchange Programme (NEP).

6 Syringe Containers



The original 1988 container for returning used syringes.



The 2007 container for returning used syringes.



The 2007 returns container from a different angle.



There is a significant difference in size between the earliest and the current returns container.

7 Chronology and statistical parameters of the NEP

The prevention of HIV transmission in marginalised communities was organised through state policies implemented largely by corporate AIDS service organisations, such as the NEP peer groups, the New Zealand Prostitutes Collective (NZPC), and the New Zealand AIDS Foundation (NZAF). The NZAF emerged first in the mid-1980s from a network of community groups to form a single corporate trust, which became increasingly professionalised (Lindberg & McMorland, 1996). The NZPC and the NEP peer groups corporatised and professionalised to a less intense degree, in ways that responded to different community environments and cultural expectations.

The NEP has supplied syringes through two types of outlet, but initially there was only one type. This consisted of the pharmacies that had volunteered to register into the NEP. In September 1988, seven months after the NEP began, there were 149 of these registered pharmacy outlets (Kemp, 2004). Between that time and 2004, the number of registered pharmacies varied between 100 and 200. In late 2004 there were 170 pharmacies registered with the NEP out of the 900 pharmacies in total throughout New Zealand.⁵⁷⁹ This enrolment provided a modicum of national coverage, except for towns and rural areas. However, in a sprawling city such as Auckland, it was possible for pharmacy numbers to drop in some suburbs, creating local gaps in services.

Five months after the NEP pharmacies began operating in May 1988, an initial set of IDU peer groups were contracted by the Department of Health. These experimental service contracts specified outputs that included the provision of educational material, the expectation of peer-to-peer communication with IDU, the supply of syringes, and the collection of returned syringes. The initial descriptions⁵⁸⁰ of these contracts include a concept of IDU being represented by these peer groups. However, this aspect was underplayed in public descriptions of the NEP. Furthermore, the references to advocacy were quickly removed from the formal contracts, amidst controversy and resistance by the peer groups. During this period the number of these peer groups increased to five by 1990, then remained unchanged until late 1994,⁵⁸¹ when one publicly collapsed, but was rapidly replaced.⁵⁸² This episode marked the end of the foundational, and the post-foundational plateau era.

579. See Sheridan, Henderson, Greenhill, & Smith (2005).

580. As found in several Department reports.

581. See Auerbach (1994); Walzl (1994). The groups were ADIO, IV Union, WIDE, CIVDURG, and DIVO. Auerbach and Walzl do not name more than these five. It may be that some different groups started but soon disappeared. The extremely poor quality record keeping by state agency officials during this period makes an extra group appearing in a count at any one time quite feasible. However, Kemp (2004) reports there being six peer groups in 1993, and ten in 1995, but does not name them. Ten groups would have provided far better regional coverage of outreach, but would have used funding that was prioritised elsewhere by officials, and desperately lobbied for by the five underfunded publicly known groups. By contrast, in 1999, in a guide to HIV/AIDS for health professionals, Prince & Meech (1999: 97) report only five peer groups when there were at least 11. However, the authors have not acknowledged any consultation with NENZ in the preparation of their authoritative guide, which might explain such inaccuracy over the details of the NEP. In 2000, a Ministry memo lists 11 groups by name (Ministry of Health, 2000). I leave it to the reader to decide what these discrepancies might indicate.

582. By public I mean there was widespread knowledge within the HIV/AIDS, IDU, and addiction treatment networks. However, there was no media publicity. Other groups had at times been forced to change personnel, or reconstitute Trust Boards, but never so drastically or publicly.

The incident coincided with the founding of a new pattern of national co-ordination achieved through the autonomous trust called Needle Exchange New Zealand (NENZ). NENZ overlaid the regional autonomy of the five peer groups, partly weakening yet largely supporting that autonomy.

The five peer groups formed NENZ as a national federation in 1995. Due to the support from this federation, new peer groups of a similar type to the initial five began to be established. By 2004 there were twelve full-time centres, two part-time centres, and one de-centred service on the West Coast (Sheridan, Henderson, Greenhill, & Smith, 2005). In addition, the larger cities of Auckland and Christchurch had begun to establish suburban satellite outlets. In 1995 the outlets were reclassified as either Level 1 or Level 2. The Level 2 outlets were 'dedicated' exchanges, which included all the peer group centres and a small number of pharmacies. These Level 2 outlets provided a peer-professional level of specialised services. These services emphasised the agency of IDU clients by offering choices. The selection on offer focused on increasing the degree of control over the risks of injecting. Level 1 outlets only provided a basic, 'one size fits all', level of syringe exchange. Level 1 outlets relied on pamphlets to offer information on advisory and referral services. In both types of outlet the supply side was completely commercial, with the price of the syringes, paid by the IDU client at the time of the transaction, providing a professional service fee and reimbursement for labour.

By 1990, the regular patterns of attendance and usage by IDU customers were being recorded as a contractual output to satisfy the official funding and registration agencies. The peer groups which had been founded in 1989 and 1990 had all formally joined the NEP by 1991. The initial governance issues between peer group Trust Boards and their founding co-ordinators had mostly been resolved by 1995. Moreover, the number of syringes distributed through the NEP increased steadily to over 1 million per annum by 2000. Of these, 64% were supplied through peer groups (Kemp, 2004). The original goal of reducing HIV-related harms in IDU had been achieved by the peer groups becoming as significant as the pharmacies, though in different ways, for the supply of syringes. Yet despite the increased access to sterile syringes, HCV remained prevalent among IDU.

About 1,300 New Zealanders have been estimated to become newly infected with HCV per annum, while estimations based on standard disease modelling are in the order of 1280 cases acquired per year.⁵⁸³ A study of HCV incidence in new injectors in the mid-1990s in a single city indicated a 13% per annum acquisition rate (Brunton et al., 2000). Assuming that 5% of the population over this period were IDU, and projecting the 13% acquisition rate onto the consequent estimate of 2,204 new injectors, approximately 386 consequent cases of HCV per annum would be expected. However, only 60 to 100 infections have been notified annually after acute cases of hepatitis C became legally notifiable in 1996. This discrepancy may be due to many instances of infection

583. See Hepatitis C Resource Centre (2007), Brunton (2005. pers. com.), Easton (2002), Brunton (2000), Nesdale, Baker, Gane, Kemp, Brunton, Law, & Garrett (2000).

leading to chronic infection, or clearance without treatment, yet with no acute phase that could be easily diagnosed and notified.

It is likely that many people will not be tested for HCV. There is no population-wide sentinel testing. GPs do not promote testing without significant symptoms to justify the expense of a test to the state agencies that provide diagnostic testing funding. Given the limited means of transmission after the national blood bank supply began to be tested for HCV, a request for a test by a patient is effectively a disclosure of IDU practices. Such disclosure is hazardous to individual IDU in terms of insurance coverage, custody disputes, social reputation, overseas travel, pain relief in emergencies, and bigotry from many medical professionals. Any non-disclosure, or non-compliance with testing, is significant in explaining how the estimated incidence of HCV might greatly exceed the notified rate, and even exceed the recorded rate of initiation to injecting drug use.

The situation as regards HCV also illustrates the significance of stigma and secrecy in the zones between crime and health systems. The estimated HCV transmission rate is directly evidenced not by epidemiological survey, nor by doctor-patient compliance and notification, but by the level of demand for syringes and the testing of NEP attendees. Both the studies of HCV prevalence and the records of the supply of syringes are reliable measurements because the volunteers being studied are not motivated to deceive, and IDU are not motivated to alter their rate of exchanging syringes.

Since the use of sterile syringes reduces HCV transmission, and has not been shown to increase rates of initiation to injecting drug use, it seems likely that greater numbers of people have been injecting substances than general population surveys have indicated.⁵⁸⁴ The lowering of syringe prices, and increased coverage by a greater number of peer group NEP outlets, would explain how a relatively stable IDU population might increase its syringe circulation rate. For instance, the proportion of syringes returned for disposal improved from recorded national averages of 37% of sales between 1990 and 1994, to 52.9% of sales in 2000.⁵⁸⁵ Moreover, the discrepancies between the types of indicators may be due to increased levels of recreational injection that were not admitted by participants in the telephone-based Comparison Surveys of illicit drug use. The self-reporting of criminal activities seems inherently biased towards an unknown degree of underestimation. Nonetheless, these quantitative numerical data certainly hint at the scale and significance of the injecting and HCV situation addressed by the NEP.

Quantitative data directly describes the numerical size of a category of measurement. Such estimates lead more indirectly to an account of a narrowly measured segment of actual life phenomena. By comparison, qualitative information directly indicates the forms of relationships, as

584. For instance, steroids and stimulants have become more generally used and more commonly injected than in 1989, according to the National Drug Policy (Ministry of Health, 1998a).

585. See Ministry of Health (2002); NENZ (2005).

understood by those who participate in such relationships. Both quantitative and qualitative information are useful in understanding the injecting and HCV situations faced by the NEP. For example, bleach has been relied on as an approved backup method of sterilising syringes, since the user-pays aspect of the NEP has given IDU an incentive to economise by reusing syringes. Bleach was sufficiently effective against HIV for this pragmatic compromise to be acceptable by expert medical authorities, such as the AIDS Advisory Committee.⁵⁸⁶ However, by 1998, quantitative studies indicated that bleach was less effective than thought against HIV and relatively ineffective against HCV. With no effective backup method of sterilisation, the gaps in the efficacy of the NEP increased in significance. A qualitative analysis, as here, describes how such gaps required decreasing the barriers and increasing the incentives for IDU to always use new syringes. By combining the counting and motivational processes the situation becomes clearer. We understand better from the accounts and stories how the pressures on the NEP budgeting and on its range of governance systems increased to a critical level. Yet when the funding for the counting research requires a story of urgency to establish its legitimacy, the qualitative research needs to come first, as in this thesis which among other things, outlines the structural relationships that constitute NEP activities.

The national federated body of the peer groups and the dedicated pharmacy outlets is a Trust called Needle Exchange New Zealand (NENZ). NENZ is a co-ordinating and umbrella body which meets twice yearly.⁵⁸⁷ NENZ elects representatives to the NEP Stakeholder Group, which also meets twice yearly to monitor governance and policy issues. The Stakeholder Group includes representatives of the Ministry of Health, the Pharmaceutical Society of New Zealand Inc., and the Pharmacy Guild of New Zealand Inc. (NENZ, 2005).

This structure of the NEP has been maintained since the incorporation of NENZ in early 1995. However, NENZ was preceded by five co-ordinating agencies which were disestablished by mid-1995. These were the IV League,⁵⁸⁸ the AIDS Taskforce,⁵⁸⁹ the Community AIDS Service

586. For instance, in a context of the National Council on AIDS recommending that needle exchanges be provided in prisons, Dr. Meech disagreed and stated that according to the AIDS Advisory Committee which he chaired, bleach and needle exchange were equally effective (National Council on AIDS, 1989a: 3). This dissent weakened the health rationale for exchanging syringes in prisons.

587. Each local trust selects two representatives to the national board. In practice, one of these delegates has been the outlet manager (Henderson, 2005 pers. com.). This creates a situation where managers exert a collective influence, and accountability, over their own work conditions. The other half of the NENZ Board are Trustees of peer groups. Government policy has been for peer group managers to not have undue direct influence over their own employment conditions through sitting on their own Trust Boards, since such situations led to problems after the NEP began. This is one of the few areas where state agencies have directly exerted control over the private peer groups.

588. The IV League was a lobbying organisation representing IDU. It was active from 1986 to 1988. It collapsed after it succeeded in promoting new political goals and new organisational models for IDU and the NEP. Its collapse was precipitated by withdrawal of government funding by the AIDS Task Force in 1988, at the same time as the Auckland Drug Information Outreach (ADIO) peer group received its first contract (National Council on AIDS, 1988b).

589. The AIDS Task Force was the final of a succession of similarly named organisations dating from an Auckland Hospital based organisation of medical professionals that self-organised, supposedly independently of state officialdom, in 1983 (Lichtenstein, 1996: 407a). The last two versions of an AIDS Task Force were dedicated units, fully within the Department of Health, that were active from 1989 to 1990 (National Council on AIDS, 1989b: 4),

Organisations of New Zealand,⁵⁹⁰ the National Council on AIDS,⁵⁹¹ and the Public Health Commission.⁵⁹² The continuing sustainability and effectiveness of NENZ has been indicated by its management of two significant issues over the nine years after its founding. In the first situation, NENZ threatened the Ministry of Health with a nation-wide strike by the peer-professional groups in 2001 (Ministry of Health, 2001). In the second situation, the adherence by the Ministry of Health to rigid funding limits was 'by-passed' through direct intervention by the Associate Minister of Health. This by-pass led to state funding of free syringes in 2004 (Henderson, 2005 pers. com.).

The regulatory environment of the NEP has been durable but not particularly adaptive. In November 1987 changes to the Health Act legalised the provision of syringes, and changes to the Misuse of Drugs Act partly decriminalised the possession of syringes. The Health (Needles and Syringes) Regulations 1987 were in place by early 1988. Despite significant changes in the NEP's infrastructure and commodities, these regulations remained unchanged for ten years until an amendment to the Misuse of Drugs Act replaced the Health (Needles and Syringes) Regulations 1998. Further amendment to the Misuse of Drugs Act occurred in 2004 with the introduction of a free one-for-one exchange system, and again in 2005 when the onus of proof in charges of possession of syringes shifted from the defendant to the prosecution.

The NEP's relatively stable regulatory environment is partly explained by the rapid halting of HIV transmission among IDU. The sharing of syringes, as self-reported, reduced from 50% in 1994 to 6% in 2002 (Aitken, 2002). Between 1985 and 2003, those diagnosed with HIV numbered less than ten per annum, a rate which included infections acquired overseas (Saxton & Hughes, 2004: 8). Peer-professionalism in relation to HIV has influenced the timing of the NEP's delayed regulatory changes by being effective and efficient. However, the accounts and stories of HCV have been different. The differences between the studies of sample populations, and the incidents reported through notification, illustrate the significance of HCV being a disease of secret, marginalised practices and networks. HCV is similar to HIV in being unable to be feasibly prevented by standard

then from 1990 to to 1991 (Fithian, 2004 pers. com.), when it was disestablished.

590. CASONZ became organised by September 1989 (CASONZ, 1990a; National Council on AIDS, 1989d: 2; CIVDURG, 1989) as a local version of the International Community AIDS Service Organisations, which had been intended as an international model for community AIDS Service Organisations (National Council on AIDS, 1989d: 2). CASONZ was positioned as a potential vehicle to improve the uniformity of coverage of outreach, a problem acknowledged by the National Council on AIDS (1989c). CASONZ had increasingly criticised government policies, especially integration of STD services with specialised HIV/AIDS services such as provided by the NZAF. CASONZ had also criticised increasing cutbacks in HIV/AIDS prevention services, which were implemented and represented by the AIDS TaskForce. Integration with STD services and funding cutbacks both threatened the ability of peer groups to provide outreach services. CASONZ collapsed after its funding was reduced in 1991, then withdrawn by the AIDS TaskForce in 1992.

591. The National Council on AIDS was a policy co-ordinating 'think-tank' that represented a broad cross-section of New Zealand society. It was formed to complement the AIDS Advisory Committee in 1988, becoming formally constituted in 1989, in a process that also formed the majority of the AIDS Advisory Committee into a separate Medical and Scientific Subcommittee of the National Council on AIDS. The process made political differences within the AIDS Advisory Committee more formal and manageable from a Government perspective.

592. The Public Health Commission was a mid to high level central funding and co-ordination agency sited under the governance level Ministry of Health after the Department of Health was disestablished in 1993. The Public Health Commission retained a HIV/AIDS services co-ordinating committee until the Commission was disestablished in

health promotion methods. This has led to 'harm minimising' changes to the NEP regulations and policy in 1998 and 2004. Since the transmission of HCV is associated with the exclusion and stigma of IDU, the requirement for empowerment of IDU communities and increases in individual self-esteem has led to an increased harm reduction emphasis, at least at the instrumental level of NEP activities, since 1988.

8 Harm reduction and harm minimisation

The NEP was originally described by Cabinet members such as Judy Keall (1987), and the Department of Health (Baker, 1987c: 2), as 'reducing' the risk of disease while increasing enforcement measures. The Explanatory Note attached to the Health (Needles and Syringes) Regulations 1987 (New Zealand Government, 1987) referred to 'minimising' the risk of disease. The intent seems equivalent in both usages. The NEP Management Plan of the same period aimed to 'significantly reduce' the spread of HIV/AIDS, yet positioned abstinence alongside sexual monogamy as linked ideals (Baker, 1987c: 2).⁵⁹³ The imputation that both were ideals that could not be reached or enforced appears to be understood as a harm minimising approach.

Nevertheless, the agency (the activity, not an organisation) associated with both sexual and drug desires appears to be imputed in a harm reduction manner. The way these aims were to be implemented in the Plan strongly promoted IDU agency through raising the self-esteem of IDU while they continued their illicit drug use. IDU were referred to as exerting will and motivation (Baker, 1987c: 3, 7, 29, 56, 65). A positive, non-judgemental approach by NEP workers was defined as being essential, in what appears to be a harm reduction approach.

The NEP form of harm reduction was only partly modelled on a doctor-patient relationship of individual patient compliance. It has also been modelled on the prevention of viral transmission in interactive long-term social environments. As socially interactive and representative, rather than fixated on a particular disease or group of blood-borne diseases, the NEP has aligned with modern holistic nursing, as well as with community oriented public health promotion policies.⁵⁹⁴

In 1990, Dr. Baker and Stephen Lungley were commissioned to evaluate the NEP. They concluded by advocating for a change in national drug policy from 'harm prevention to harm reduction' (Lungley & Baker, 1990: 79). A separate review of the NEP peer groups in 1990 did not refer to harm minimising or reducing, but did promote a 'harm reduction' type of argument based on increasing the self-esteem of IDU (Robinson, 1990: 26). Neither term appears in the later NEP reviews by Walzl (1994) and Auerbach (1994d). By 1995, the terms 'minimise' and 'minimisation' become more apparent, as in 'minimising risks of infection', that appears in a review of the NEP management issues (Fitzgerald, 1995: 2). The term 'harm minimisation' gained increased exposure with the release of New Zealand's *National Drug Policy* in 1998.

The *National Drug Policy* is described as being a 'harm minimising' health policy situated within the Ministry of Health.⁵⁹⁵ The NEP became included within the *National Drug Policy* as an:

593. This was because IDU acquisition of HIV did not threaten the non-IDU heterosexual population unless IDU practiced unsafe sex with non-IDU. The two acquisition routes needed to be combined for a threat to materialise. Prevention programmes were consequently aimed at simultaneously addressing both routes.

594. See Galbally (2000: 271-272), Neuman & Fawcett (2002), Ramsden (1991), Giorgi, (1985).

595. See Webb & Marriot-Lloyd (2002: 496, 500). It is unclear whether the *National Drug Policy* is wholly or partly

“attempt to minimise harm to the users and the community, even if some drug use continues and drug-related harm cannot be totally avoided” (Ministry of Health, 1998a: 43). The *National Drug Policy* (Ministry of Health, 1998a: 39) directs the NEP to improve the provision of health information and advice to at-risk groups, such as IDU, and including young people and prison inmates. However, the *National Drug Policy* also calls for increased investigation and prevention of the supply of drugs to at-risk groups, such as youth (Ministry of Health, 1998a: 39). Attention is thereby drawn to how information from the NEP might assist the directive to further develop intelligence systems and technologies to counter the availability of drugs (Ministry of Health, 1998a: 38).

The NEP is public health oriented. It neither condones nor condemns drug use, whereas the *National Drug Policy* includes attempts by enforcement agencies to condemn drug use by prosecuting and incarcerating drug users. Yet describing the NEP as harm minimisation is partly justified, though not because the NEP has changed from being 'harm reduction' in practice. Rather, it is justified because bureaucratic boundaries have shifted so that the NEP has become closer to policing activities within a collaborative assemblage of state agencies. The NEP had initially been focused on disease types of harms and syringes, before becoming strongly influenced by IDU morals, norms and interests. However, 'harm minimisation', defined as a national policy of integrating different elements in a pragmatic framework that included harm reduction (Ministry of Health, 1998a: 28), regrouped the NEP within the drug policy area of mental health,⁵⁹⁶ rather than in a distinct area of disease prevention.

As I have used the terms, harm minimisation involves links to official interests, formal policies, or the mission statements of state funded programmes.⁵⁹⁷ Harm reduction refers to engagement with IDU in outreach, and to the enhancement of their motivation by peers. In any actual use by others, the degree of imputed agency might vary. In my usage, the degree of agency referred to in harm reduction is significant, as are the official associations referred to in harm minimisation. I do not wish to extend an outline of the context of these terms much further, since my goal has been to explore, from the inside, how the NEP is characteristically active. The terms make better sense when the history and working systems of the NEP are better understood.

within the territory of the Ministry of Health. In some ways it seems a semi-independent entity, actually governed by one or several interagency committees. There are many stakeholders, but no clear accountability links. This is similar in many ways to the NEP systems, if we exchange the IDU for officials, and syringes for policy.

596. In 2002, drug treatment programmes were merged with mental health programmes, indicating professional turf wars, as well as government dissatisfaction with outcomes in either or both areas being treated separately (New Zealand Drug Foundation, 2002).

597. From 1998 the phrase 'harm reduction' in the preamble to the *National Drug Policy* was replaced by 'problem limitation', described as the 'treatment' of drug users rather than empowerment. The influence of the Ottawa Charter on New Zealand's drug policy has been systematically reversed, at least in terminology, since the late 1980s and 1990s. This is because the term 'problem' is far less evidence-based and far more open to interpretation in favour of dominant ideologies than is the term 'harm'. Furthermore, the term limitation is far less committed than the term 'reduction', since any limit, no matter how small, is still a limit, yet reduction implies a goal of continuing to reduce. This is seen in the draft of the proposed new National Drug Policy (Ministry of Health, 2006b).

The distrust created by enforcing the prohibition of drugs provided the basic logic that drove the need for harm reduction.⁵⁹⁸ Law enforcement is difficult to legitimise in harm reduction terms, because those enforced tend not to participate voluntarily through self-control. Accordingly, they will be just as much a danger to themselves and their social environment when no longer being enforced.⁵⁹⁹ This is why their motivations are as important as the safety of their material environments. However, the more the peer aspects of the NEP are acknowledged as effective and efficient, the more the conflicts intensify between reduction and minimisation within the logics of the *National Drug Policy*. These aspects illustrate how a study of NEP history and capabilities is also a study of an interagency environment of collaborating interests. The study of connections between different components of separate areas of activity, such as motivation and bureaucracy, requires the selection of analytical tools which engage with the sequencing and contingency of policy changes.⁶⁰⁰

598. See O'Malley (1999: 191-212) for a governmentality analysis of reduction and minimisation strategies.

599. However, O'Malley (1999) notes that harm reduction practices can promote individualism at the expense of control of environments.

600. See Howlett & Ramesh (1995: 3, 12-14).

9 Framing concepts

Boundary lines

One method that I have used to test my data and concepts is to diagram (Rotman, 1999) the shapes of forms, or putative forms of interactional patterns, for instance institutionalisations. I then would explore and critique the diagram, asking myself questions about its relevance, and how it might be extended, or be redrawn as more informative using different techniques of representation. The critique has two components. First the diagram is checked to see where random instances and factors relate to the shape drawn, if at all. Then, historical changes are used to problematise the relationships as drawn. How would a diagram from 1989 be redrawn in 1992? What requires change? Are there changes that escape the diagram? Why? How meaningful is the diagram?

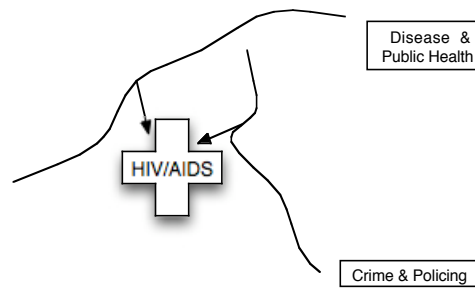
This exercise involves a formalisation of everyday reflection. The formalisation permits and encourages clarification. The exercise also leads to illustrative aids to the presentation of concepts, provided it is always kept in mind that an isolated illustration is designed to provoke meaning, not to provide an argument in itself.

The analytic exercise of topologically mapping the institutional environment of the NEP can produce a diagram of boundary lines. Visualising these imagined and expected boundaries can index a kinaesthetic, meaningful story. The indexing relies on encasing the detail and complexity of cultural narratives in lines and planes that as a single, more easily talked about yet composite shape, resists becoming a single category or object like a ‘black-box’. The apparent simplicity of such shapes is provoked by drawing a formal symbolism⁶⁰¹, as also a portrait of character, as well as a cross-sectional ideogram of a story of development.

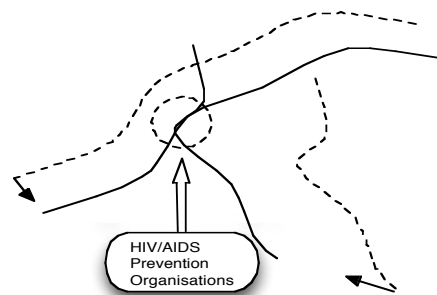
In the diagrams on the following page, the two lines are drawn as separate, because the expectations and practices involved were organised, funded, and understood as different sets of categories. Each set depicts a boundary effect between perceived problems and responses. These effects were not just divisive, since each boundary acted as a bridging zone where cross-border as well as transgressive and borderline work took place.

We note how IDU broke laws, causing police to increase their information that profiled and defined IDU. In a separate set of boundary situations, viral diseases moved into and challenged health systems, which caused health professionals to monitor the physiological and demographic viral boundaries. Such work involved categorising, labelling, applying technologies, marketing, moving objects, and transferring information.

601. A hybrid artefact of shape, discourse, and scientific research. Not a symbology, which is a whole system rather than a particular drawing. Nor a symbol, which is too referential.



The advent of HIV/AIDS altered this arrangement by attracting aspects of the boundary situations, and attaching them to each other at those aspects. At the zone of attachment, aspects of previous assemblages became juxtaposed in new unpredictable arrangements, while connected to two conventional boundary situations that remained predictable away from the zone of attachment. The constituent aspects of the boundaries attached at the locus of harm reduction programmes delivered by representatives of marginalised communities to those whom they represented. One version of such connections and distinctions is presented as Diagram 2. IDU 'crossed' boundaries into health logics, causing their relationship with police to be modified by health professionals. In a simultaneous exchange, viruses 'crossed' boundaries into legal logics. Police withdrew from these boundaries because they could not arrest viruses; health professionals withdrew from these boundaries because they could not arrest viral transmission.



This model focuses attention on significant issues through its simplicity, as well as its obvious shortcomings. For instance, the lines were not initially fully separated, since medical professionals co-operated with police in law enforcement, and police had enforced quarantine and public health regulations (Gray, 2006). Furthermore, illicit drug use had been treated as a contagious disorder. However, the lines represent institutionalised expectations, not a graph-like summation of measured numbers. In this sense the lines were distinctly different. The intersection zone associated

with HIV was part of at least two lines which remained largely distinct and resisted integration. Again, the diagram's shortcomings provokes analytical narratives. How might one represent the intersection as story lines? Did they merge, or knot or attract? Were they tied together by other factors? How far along each line might the effects of local intersections be represented?

The attention I pay to shapes and stories has focused more precisely on how movements of institutional structures and shapes extend longitudinally to how effects worked out as temporal sequences of events. Flat structural relations and long temporal events can be conveyed in accounts and stories which can be arranged by means of a single narrative in the combined logos and logic of a case. In the case of the NEP, the partly resultant partly self-maintaining combination of shaping and sequencing also describes how peer-professionalism interacted with its environments of health promotion and drug prohibition.

Mechanisms

I have used concepts of ‘mechanisms’ and ‘active networks’ to delineate aspects of the NEP. In my usage, which emerged from this research, mechanisms can be identified by a significant degree of regularity, internal structure, feedback, and coherent movements of components. The significance of such a mechanism lies in its capabilities of explaining how organised patterns of interactivity can be co-ordinated on a wide scale, while not requiring any central individual or group to carry out planning at the scale of the effects being observed and modelled.

A mechanism distributes agency across a network of participants, similar to how on the bridge of a modern warship, individual qualified specialists, with computerised information systems, and official protocols of hierarchical feedback from the whole floating configuration of componentry, are all required for a competent direction of the vessel’s course. Mechanisms of this sort, in the context of policy courses, construct effects such as forms of health care, trust, and knowledge, where complex interactions create continual opportunities for adaptive reconfigurations. How the specialised and sheltered expertise of the NEP was produced is usefully grasped as a mechanism where different elements produced a joint effect.

The metaphors of complexity I employ to describe hybridity, for instance in section 5 that follows, draw attention to how phenomena such as the NEP can be more readily grasped and usefully understood. I have found both aspects in the relationship between the NEP and what I call peer-professionalism. The complexity of interfaces between motivations and activities, where both patterns and contingencies abound, are also a “matter of ‘simplicity’ and ‘complicity’”.

Simplicity is the tendency of simple rules to emerge from underlying disorder and complexity, in systems whose large-scale structure is independent of the fine details of their substructure. Complicity is the the tendency of interacting systems to coevolve in a manner that changes both, leading to a growth of complexity from simple beginnings ... unpredictable in detail, but whose general course is comprehensible and foreseeable. (Cohen & Stewart, 1995: 3)

There seems no single, clear resolution to the complex agency at work, creating and occupying spaces among and between the NEP, its peer-professionals, and its networked environment. However the concept of ‘mechanism’ offers a way of presenting this key issue of the relationships between case studies and network activity.

Mechanisms, like actor-network methods, resist prior categorisation and entity boundaries by inherently destabilising essentialist presumptions of a normal status-quo. Mechanisms encourage analyses that locate the activity of control, the working out of difficulties, the way different directions and perspectives lead to different representations, and the ways in which forms of authority become more or less sustainable. My earlier accounts were improved by trying to tell a range of stories linked by a single component rather than a single account. I increasingly utilised the concept of ‘mechanism’ to explain regular patterns that appeared in all the stories. Mechanisms,

as I use the term, generate effects through the co-ordination of regular movements, actants, and constraints in a system that includes feedback. Movement necessarily involves temporality, but in a mechanism many things happen effectively at the same time, or in delayed responses to environmental responses, rather than in simple, predetermined causal sequences. Mechanisms can involve random and switching elements⁶⁰² to generate effects not intended to be predictable, or are unpredictable in practice due to the complexity of cybernetic feedback loops. I find mechanisms more lifelike than systems. Mechanisms express a greater reliance on their own boundaries, locality, modularities, and intersections. These resist assumptions common to systems logics that outcomes are better if the scope is totalising, the initial and default states are uncontested, and the evaluation is functional.

My analysis of the NEP was sensitised by actor-network approaches and Deleuzian concepts that have a lot to say about deviant experiences. These shaped experiences articulate the production of effects from the ‘surfaces of operational activity’ rather than depending upon the assumed inner essence and cohesive processes of social organisations. The activity of surfaces between boundaries, or processes, or circulations of object movements, as in Deleuze and Guattari’s concepts of ‘machinic assemblages’⁶⁰³, seemed to fit well with hybridity. Yet I use the term ‘mechanism’ because it is less localised, not so commodified nor denigrated as a gadget, and less inherently material than ‘machine’. Mechanism carries more sense of unexceptional, though unpredictable, iterations of innovation⁶⁰⁴. Mechanism emphasises how work is seen in actual movements, whereas ‘structure’, and even ‘pattern’, emphasise rigidity and constraint. Moreover, where the model-metaphor of ‘machine’ is extended, as in ‘political machine’, the tone is generally denigrating and dismissive. ‘Mechanism’ seems to express a more appropriate ambiguity between desire and distaste in a postmodern western culture. Blaikie distinguishes between narrative mechanisms that explain and retroductive mechanisms that “generate the regularity to be explained” (2000: 169). I use the strong latter sense to explain the regular cycle effect and structural boundary work effects of the NEP. Yet I consider that both meanings are usefully

602. Of course, if any feedback element is introduced the mechanism starts counting time and inscribing time into the products of its operations. The products might include personal identity as ‘age’, and social identity as ‘times’.

603. Lacan claimed to have invented the term ‘machinic assemblage’ (Seigworth 2005: 162), but I see no evidence for that. More importantly, the usage of ‘machinic assemblages’ by Deleuze and Guattari is very different from Lacan’s. I use the version of Deleuze and Guattari (2004: 4, 18, 24-25, 38, 79-80, 98-99, 234, 282, 378, 382, 480-481), Seigworth (2005), Surin (2005: 25-28). Bogue (2002: 117-119, 121, 125, 130), Colebrook (2002: xx, 79, 140-144). For a nuanced critique see Žižek (2004: 19-32). For an ideologically hostile critique see Bricmont & Sokal (1999). ‘Meshwork’ is a term used in preference by De Landa (1999: 36), but seems to indicate too much neutrality and form, though I appreciate the ambiguity between a mesh as worked on at the same time as working on. I offer an alternate metaphor of gastronomy, where taste, texture, and technology are digested together, sometimes as a ‘flat’ banquet and other times as a sequence of courses.

604. Deleuze, critiquing historicist analytical methods, considered that anything new necessarily emerges from adaptive iteration. Since any newness of human significance results from overcoming the material conditions of the time, yet in a way that is neither completely out of or in time. Deleuze conceptualises ‘excess’ as a type of freedom that by changing human conditions may change the causation of events as perceived and signified. Such grounded, immanent agency entwines with actual situations producing both histories and hope (1995: 170-171). See commentary by Žižek (2004: 10-12, 14-15). I use aspects of Deleuze, but as commentary or insightful metaphor, not framing.

combined in the form and method of analogy and metaphor.

Encasement logics

This is embodied research, featuring ethnographic elements where the researcher's physical and emotional participation has been used as an instrument, alongside culturally inscribed meanings, institutional codes of behaviour, and historical accounts. However, somatic bodies do not live as words, nor easily grasp institutional bodies and boundaries, let alone historical sequence patterns, and least of all the articulated surfaces of structural forms and forces of meaning. This is partly why I have linked somatic bodies to networks of distributed identities, organisations, non-human organisms, and objects. Yet the complicated sequence of events and complex interaction of factors involved in such linkages raise a problem of selecting the most useful information and frameworks for clarifying the causal patterns and contingencies of an inherently messy reality.⁶⁰⁵ Exploratory case studies can identify founding moments, critical turning points, fractional trajectories, and current possibilities.

My approach has been to explore the NEP as a case by mixing and matching my own methodology (Midgley, 2000: 146-148), linking empirical and abstract accounts⁶⁰⁶ (Bourdieu, 2004, 1999, 1977), and informed by wide sociological reading. I used three general selection principles. The first was appropriateness to the movements and restrictions in the work of maintaining the configurational boundaries of systems.⁶⁰⁷ The second was appropriateness to my available source material and goals (Crotty, 1998: 214-216), using a bricolage⁶⁰⁸ toolset made up of what combined and worked best from whatever was available. The third was to follow and question contingencies in methodical strategies (Midgley, 2000: 106-112). I attempted to be receptive to connections of convenience, since these are well-suited to exploring unique or unknown cases (Ragin, 1992: 9-11). My following approach does not imply that just anything was acceptable, since the logic of analysis needs to be well-matched to the method of gathering information.

I gathered, from all the sources available to me, all the information that seemed related to the tentative case and interactants I was following. Yet I would not claim to have followed all the strands that might have been included, nor obtained a rigorously representative sample of such information. Instead, my method selected for the most meaningful segments of information by following the partial and participatory meanings at hand, informed by my previous participant engagement. I moved across physical and infrastructural configurations, and probed where solid

605. See Latour (1993: 10-11), and Law (2004: 1-2, 61, 82). Fougere (2001) analyses New Zealand health systems as 'messy heterarchies', with implicit horizontal connectivity that is shaped and constrained with an absence of 'vertical' hierarchic boundaries. Martin & Salmond (2001) term New Zealand health policy a messy reality.

606. However, Bourdieu (2004: 4) dislikes Latour's actor-network approach to linking empirical and abstract stories.

607. See Leigh Star & Griesemer (1989), Gieryn (1983). See Fougere (2001) for New Zealand health systems as 'messy' heterarchies. A heterarchy implies horizontal connectivity and lack of 'vertical' hierarchic boundaries.

608. See Lévi-Strauss (1972: 16-36) for original usage, adapted from French meanings of 'pottering about, doing odd jobs'. For later social science use see Campbell (2004: 65, 69-74), Mackenzie (2003), Hess (1997), Preston (1996), Katovich (1995), Denzin & Lincoln (1994), Weinstein (1991), Weinstein & Weinstein (1993, 1991), Turkle & Papert (1990), Law, 1987. Usage shifted from accusation of lack of deep structure, to praise for skilled, resourceful local knowledge. See a New Zealand study of consumer responses to a type of contraceptive pill (Hester, 2005).

path-determined ‘bones’ became ‘decision-making joints’ on which networks of motivations and interests hinged. The research trail that I followed laid down a ‘signature of significance’ that branched and looped back, outlining a twisty path back to and adding to my starting questions. Similarly to drawing a map, the sources and strands which I followed ‘configured’ into a stranded portrait of the NEP. However, I could never be sure of whether the emergent surface being outlined was on the inside or outside of my fugitive case until a critical degree of texture, and contexture had become established. What initially seemed foreground might later seem background, or vice-versa. Since I included all of the information available from a source, the criteria of configuration derived partly from the selection of the source, and partly from the logical rationale used to relate segments of information. The logic required was detective in nature (Latour, 1996), making and rejecting cases based on evidence and motivations. I consider that the strands I followed and the sources I accessed were adequate for the logic of my analysis.

My search for identifiable patterns in the NEP developments was quite different from a deductive process of hypothesis proposing and testing. I used a best-fit, abductive process of assembling narrative, loose models, and articulated mechanisms. I used Blaikie’s version of abduction as a:

different logic to the other three [inductive, deductive, retroductive]. ... The starting point is the social world of the social actors being investigated: their construction of reality, their way of conceptualising and giving meaning to their social world, their tacit knowledge. This can only be discovered from accounts which social actors provide. Their reality, the way they have constructed and interpreted their activities together, is embedded in their language. Hence, the researcher has to enter their world in order to discover the motives and reasons that accompany social activities. The task is then to re-describe these motives and actions, and the situations in which they occur, in the technical language of social scientific discourse. (2000: 25)

Abduction attempts to grasp and encase unknown, possibly counter-intuitive causal aspects of divergent interests. I attempted a version of this process, partly from my previous participation in deviant and IDU networks, and partly by extending my reach to larger frameworks of cultural expectations and sociological imagination (Mills, 1959: 5-6), where I found stories of processes that articulate divergent interests. Similarly, when technologies and objects became strongly significant, as did syringes, then those actancies where motivations and materialities could be fitted and grasped together were followed as ‘inscribed meaningful objects’. My abductive strategy of grasping motivations to describe shifts in meanings thereby built up from separate incidents as described, towards the explanations that linked these separated incidents and enabled them to be written about meaningfully.

This writing might be considered a retroductive phase of analysis, itself open to critique if used to explain too much, too deeply, or too widely. According to Blaikie, retroduction starts with an observed regularity, like deduction:

but seeks a different type of explanation. In this strategy, explanation is achieved by locating the real underlying structure or mechanism that is responsible for producing the observed

regularity. To discover a structure or mechanism that has been previously unknown, the researcher has first to construct a hypothetical model of it, and then proceed to establish its existence. This may need to be done by indirect methods, as the structure or mechanism may not be directly observable. The search is for evidence of the consequences of its existence; should it exist, certain events can be expected to occur. Retroduction uses creative imagination and analogy to work back from data to an explanation. (2000: 25).

The abductive-retroductive aspect involved constructing an explanatory account of NEP developments. Yet because this was model has not been directly observable, I approached it by means of a combination of abducted motivations of actants and institutional logics, in conjunction with inducted categories of grouped incidents and relationships across different places and different times. The inductive aspect involved looking for patterns and putative categories in the multiplicity of events and effects that the account required to be valid, precise, and significant. My description of a motivational mechanism of hybrid antagonisms and my case model of peer-professionalism gathered greater inductive validity from the many instances, described in the social history chapters that follow, of a single hybrid pattern offering explanations across the multiple sites of the NEP operations, over 20 years of hectic health sector changes (Gauld, 2001a). My abductive and inductive logics were held together by the singularity of the case, by treating objects as both active and meaningful, by my approach of following rather than prescribing, and by the reflexivity of my narrative analysis. These logics worked in conjunction rather than competition⁶⁰⁹ due to the story-telling logics and the actant-following approach of my actor-network version of a single case methodology.

Because my peer-professional concept is sufficiently abstract to be potentially generalised, I have tentatively positioned this peer-professionalism concept as a formal mid-range theory, open to critique from counter-evidence or better-fitting explanation. Nonetheless, its relevance relies upon the rigour and logics of my selection and configuration of source information.

Abductive logics draw attention to how participants think and feel as actors and actants. My experiences of living and socialising with IDU have suggested to me that peer actors did not try to complexify their situations more than they felt necessary. I have also assumed that IDU, Department officials, and health professionals all pursued both rational and irrational goals in complex messy environments where they were motivated to simplify their choices (Luhmann, 1986a, 1986b, 1993, 1998). Yet in so doing, actors also further complexify their networks and general environment (*ibid*). Moreover, the social science and policy management areas are permeated by questions about how and why analysts develop confidence in the meanings of patterns of phenomena that cannot be directly touched or envisioned (Cooper & Burgoyne, 2006: 144-147) until socially imagined (Mills, 1959). My abductive descriptions of the NEP drew on what actors presented as making sense, particularly the categorical boundaries that structured and

609. See Blaikie (2000: 262-276) on the difficulties of mixing different measurements or methods.

simplified complexity by naming and expecting specialisation from institutions and organisations.

My case study⁶¹⁰ approach has invited the emergence of analytical insight from messy network complexities⁶¹¹ by incorporating direct numerical measurements, topological articulation, and narrative sequences. These methods suited the NEP's small size and isolated situation, as well as its record of existing for 20 years as an 'exceptional' policy intervention. I sought to portray the character and context of the NEP's identity (White, 1992: 91-92) as a case in order to better understand its capabilities. The structural component of my analysis began and continued using my versions of actor-network approaches, where a case is initially treated as an effect that is a combination of effects rather than an essential, singular entity that 'counts as one' (Badiou, 2007). Such approaches have been developed from case studies of material technologies and scientific expertise and so seemed suited to a social technology based on syringes and expressed in a formal programme. Nonetheless, as I explored connections and followed activity from the inside of the case, I minimised my conceptual repertoire to the minimum of what the described material required to make sense. This mixed boundary analysis work (White, 1992: 93-94) engages with the crucial question of reconstructing the relationship of internal to external processes in the making and maintaining of what makes a case whole in activity, even if partial and multiple in constitution.

Case studies are useful because they can include a mix of interactions, where environments and motivations shift with time, entangled with the abstractive concepts and symbols that enable spoken and written communication. When actual outcomes, managerial methods, or inputs to policy intervention are being researched, it is cases that are studied. Single cases relate to reality, not by shifting from generalities to the correlation of a few key specifics, but by performing a range and depth of solid, durable existence. Cases can affirm, by means of their immanence as quasi-objects, their own actuality of boundaries, causes, and sequences of events. Cases are always constituted from 'wrapping-up' the abstract interpretations and categorisations of solid boundary elements. This is done somewhere between the case actants and a researcher who is also an unfixed actor moving in and out of 'the case', trailing narrative threads. Yet researchers cannot be certain that a full set of case documents has been accessed, or that the case contexts of meanings have not changed imperceptibly, resisting any quick and easy fix. Cases are never fixed, which keeps the question of prioritising sources, and their degree of saturation, always potentially open, like a coffin with an inside latch.

I came to describe the NEP case in terms of an accumulation of self-modifying repeating patterns,

610. For discussion of cases studies, see Van Evera (1997: 51-55), Ragin (1992), Abbott (1990, 1992b), Becker (1992).

611. I mostly use qualitative methods, but these do not in themselves explain how I understand and articulate the constituent contexts, coherencies, and boundaries of a case, nor why I value a case approach, since quantitative methods can be used with case studies and are appropriate for particular questions and sources. For discussions of case studies and complex systems, see Blackman (2006), Stinchcombe (2005: 144-152), Stacey (2003), Sweeney & Griffiths (2002), Higginbotham, Albrecht, & Connor (2001), Byrne (1998), Clarke & Stewart (1997), Eve, Horsfall & Lee (1997). See also Klir (2006), Ragin (2000) on fuzzy-set methodology.

or cycles. I conceived of these cycles as describing actual events, not as determining or foundational structures. These ‘cycle stories’ explained how longer-term institutional factors contributed to similar responses to contingent factors, thus drawing analytic attention to relationships between structural, temporal, and contingent aspects. Such partial and multiple aspects, along with unexpected sources and re-prioritisation of information, ‘queered’ the NEP case for being singular. Instead of trying to formally ‘straighten and fix’ the case boundaries and source material, I attempted to utilise these ambiguities as a source of analytical insight. My analytical method used narrative to associate the boundaries of object movements and human motivations, within a context of the inherent ‘interests’ of viruses⁶¹² in growth, and institutional ‘interests’ in the fixing of boundaries.

Some criticisms of case studies (Blaikie, 2000: 213-225) include the claim that case research cannot be replicated due to the high degree of input from the researcher (Blaikie, 2000: 218) into selecting its boundaries and description. Yet this criticism is only partly valid, since case studies are intended to be compared, constellated, and re-approached, not replicated, nor compared with a placebo situation. The material and relational features of the NEP case, for instance, can always be reappraised from another research approach. Even the most rigorous research methods are influenced by motives, and cannot be fully duplicated unless the report contains the raw data, making much longer documents and harder to read text in support of research arguments.

Case studies have also been criticised for being resource hungry and producing embarrassing large data-sets (Cooper & Burgoyne, 2006: 151). Yet I prefer excess amounts to over-controlled information, since assumptions that limit information prior to searching prevent that actually used being challenged during analysis by the unknown absent data, adding rather than subtracting from the self-limiting circularity featuring in any analysis.

Case studies have also been considered unsuited for generalisation. However, this is not a problem with case study methods as such, but rather with the degree of abstraction and strength of the universalism of the general claims being made. Furthermore, a case study is completely generalisable within its own boundaries, the character and positioning of such being a key component of case analysis. Generalising can be potentially achieved by extending the case boundaries. The ‘lack of generality’ critique seems more aimed at relational sociology in general.

612. It may be objected that viruses do not have interests. From my perspective, I am hunting viruses for information. To do so I need to identify with viruses, to understand their perceptive surfaces, to move towards an open meeting place in order to achieve instances of closure. In such a strategic configuring, interests cannot be safely specialised, but rather assumed to be distributed across interacting species. A ‘human’ virus may be assumed to ‘have’ interests in humans. More to the point is whether currently unknown viruses outside testing regimes have interests outside their hosts. That seems another story.

Narrative Logics

I have presented a set of stories as I came to understand them, while looking for shifts in the understandings, expectations, key connections, and conflicts which the NEP actors themselves represented, along with objects and viruses, as accounting for events. This ‘translation approach’⁶¹³ parallels the way Latour’s concept of processes of consolidation, which work through objects such as documents, engage with processes that oppose consolidation. I have described how syringes have acted in the NEP network by resisting being limited to a single meaning and a single organisational response, and by retaining a capability for deviant action even when formally decriminalised. As actants, the syringes connected the blood circulation systems of individual bodies into a distributed network of viruses, cells, drugs, stories of trust, and stories of acceptable risk. This could not be consolidated, except partially, in a set of stories. Yet as stories that translated other stories, the IDU in this network became more normalised as a community, especially the peer-professionals who had been initially recruited to normalise the motivations of IDU through outreach techniques. In one story, I use processes of actancy and translation to explain how these IDU peers gained in social status, through working inside the boundaries of the institution of the NEP, while their drugs in the same networks became more criminalised outside these boundaries.

Networks are not time-bound in the same way as are single causal sequences, since multiple factors are simultaneously present and active in producing effects. Such effects differ from those produced by the activity of a preceding effect. The complexity of network embedment explains the necessity and problems of narrative analysis (Midgley, 2000: 70-78, Crotty, 1998: 48-51, 105-111).

Narratives feature “the organization of material in a chronologically sequential order and the focusing of the content into a single coherent story, albeit with sub-plots” (Stone, 2001: 281). Simple sequences ‘demand’ to be narrated through the mutual affinity of their organising logics, yet complex embedments in networks ‘need’ to be translated into narrative form to be accessible and useful to social participants. Since narrativity cannot be avoided in social life, social agents are encouraged to separate out and neutralise non-sequential aspects that may be carried as paradoxical elements along with stories into everyday life and policy arenas. Accordingly, the things that ‘normalise’ in invisible forms of social action through not appearing to change, and the things that happen in complex interactions where sequence is unclear, are prone to be left out of stories.

If the material constraints and informative stories permeate a case, then their activity may be

613. ‘Translation’ describes processes whereby information and motivation becomes changed in meaning by being moved, perhaps across distances, perhaps into a bounded locale, or perhaps in terms of changes in the connectivity of assemblages. These are all types of movement, or resistance to movement, which are likely to occur in combinations. Such processes align the participating actors and agencies into a mutual though disjunctive sense of a consolidated understanding, despite the changes and differences produced during the process. Callon locates ‘translation’ in a sequence of stages of ‘problematization’, ‘interessement’, ‘enrolment’, and ‘mobilisation’ (1999).

expected to be well-evidenced with overt consequences, automatically selecting for relevance, so long as the 'things themselves' are relentlessly engaged with. A sequenced, explanatory account produced by researchers will try to shift around, excusing its weak points. This actancy between the demands of the research account and the situation of the hapless researcher attracts a reflexive attention towards the gaps that outline missing stories and actants in the patterns of network activity. The activity being sought can be thought of as an 'environmental mechanism', because effects are produced and selected for in partly regular, repeating ways, through shaped and aligned activity. This perspective aligns with the 'followability' concepts of Gallie (1968, as cited in Abbott, 1992b). This methodology focuses on how things actually happened. Narrative is considered: "itself explanatory by virtue of truth, consistent chronology, and a coherent central subject ... to combine things that are determined by general laws with things that are contingent, producing a plausible, because followable, story" (Abbott, 1992b: 68).

The power of case analysis lies in using narratives to simplify more complex processes and to grasp useful packages from unwieldy amounts of potential information, regardless of where and when those processes and information sources ramify. Following what is seen to connect, to be proximate in being contingent, seems not only a convenient but also a productive case study technique. A researcher will go as far as they are able, before presenting the latest of their provisional descriptions of the boundaries not only of 'a case' but also of 'the research' (Opie, 1994: 67-69, 77-81).

The critical point here is that narratives act to group occurrences and events in a range of ways, yet which are all dependent on sequential ordering along a temporal axis (Tilly 2002: ix), and which all involving a mutual dependency on the unidirectional sequencing of speech. Causation is experienced as strongly narrativised in the way in which that which convincingly comes first strongly influences what can be said and understood later. Furthermore, causation is required to be accounted for in this way in order to make sense as a story that links a wider collective audience. Such causative connections might be simple and linear; or more likely, might produce complex effects by altering environments that are constituted through interactions of path-constrained options, amid niches of opportunity, in network conjunctions. The complex articulation of the local environment, like a 'soft machine' (Burroughs, 1992), resists unidirectional narrativity in an explanation of how it works. Accordingly, a useful account must necessarily compress some aspects into a pretence of a single simple effect, and leave other things out,⁶¹⁴ whereas stories are not so accountable.

Actor-networks

614. See Tilly (2002: xiii). Leaving things out is accepted providing the more significant things remain. Yet significance in research cannot be assumed, since changes in significance would seem the most valuable finding of any study.

I have used actor-network methods of following the representational processes of empowerment and enrolment to reposition the NEP as an active effect emerging from multiple elements of different types, and from the timing of activity. The actor-network methods have also been used to re-present the NEP as a categorised entity with the capabilities and vulnerabilities of a condensed, narrow zone of action, yet deliberately and reflectively. The connections between various actants, including non-human viruses, contributed as a distributed activity to the more narrowly focused effect of destabilised institutional and professional boundaries. These were encouraged to realign in a different form of organisational interaction which a small number of strategically influential policy entrepreneurs found more useful than the previous arrangements.

The initial boundaries did not break, nor disappear, but rather folded and kinked into a new shape which then became stabilised as an organisational and occupational niche, before consolidating somewhat further into an ambiguous institutional knotted niche. For instance, the illicit pharmacy syringe supply which directly and narrowly responded to HIV/AIDS provided a new and bent set of 'working boundaries'. These boundaries of successful practice destabilised the other approaches which were only being negotiated between interest groups at that time. The workable boundaries confronted the legal approaches to prohibiting drug use, as well as competing with the evidence backing the medical approaches to preventing HIV/AIDS through increases in counselling treatment. Yet such illicit success did not immediately threaten to extend and get out of control.

The boundaries have been effects maintained by imagination and shaped by the circulations of objects and information. These movements are seen to bind in time on a tight circulatory mode, yet also in a longer duration mode of events that can be identified by changes in boundaries and the patterns of circulation. These distinctions and iteration could be described mathematically, for instance in set theory (Badiou, 2007), or in diagrams, as well as accounts, stories, poetry and iconic images.

This framing echoes the Buddhist dharmic concepts and experience of 'dependent origination' also translated as 'co-dependent origination' or 'causal interdependence'. These terms refer to a situation where an illusory effect of an essential self identity (arguably also a thing identity as an objectified self) is experienced by means of embodied meditational practices as 'empty' of such essential qualities. The classic Buddhist concept of dependent causes or conditions has been expressed as 'With this as condition, That arises. With this NOT as condition, That does NOT arise.' I interpret the negation used in this expression as being four-fold, in describing relationships that are 'neither the same, nor different, nor both the same and different, nor neither the same nor different'. Similarly, my actor-network analysis has avoided causes based on mass effects of similarity, also avoided simple contradictions such as in forms of internal critique, avoided postulating a single thing with contradictory aspects, and avoid a 'nothingness' that cannot be

usefully and empirically described.

Having avoided these four tempting but inadequate analytical models, I have pursued a model based on antagonisms rather than differences or similarities, on multiplicity rather than singularity or 'nothingness', and on circulating rather than 'doing or 'going' in subjective or objective routines. I consider both Buddhism and actor-network to express a renouncing, nomadic character. Nonetheless, although informed and sensitised by these concepts, I did not follow them, because I instead followed the actants wherever the actants led.

Hybridity

The use of hybridity in this thesis refers to an unfixed, provisionally stable and productive arrangement of a small number⁶¹⁵ of antagonisms, held together through organised effort and becoming a form of systemic work. The Buddhist analytical tactic of four-fold negation which matched a pattern I observed in the NEP of 'not this, not that, not both, not neither'. Yet this hybridity, as I apply the concept, is not 'transcendent' in any sense of its meaning and activity being reliant on its 'standing outside' experienced reality in some domain of metaphysical ideals. My hybridity also does not refer to joining in the sense of merging, or of producing a well-defined, internally stable product' exhibiting a boundary only with externalities from some accumulation or re-arrangement of differences. Instead, the internal boundary conflicts do not cease and are observed to be directly linked to the processes through which the external boundaries are formulated, and re-formulated. Both contributing elements and consolidated effect can appear simultaneously from a more complex background of co-events which may not become foregrounded.

This type of hybridity forms a selective mechanism that explains how things last and seem to participants to be workable. Such hybridity also becomes more durational, as involving a process that involves continual maintenance work of overcoming the difficulties caused by the joining of antagonisms. Actor-network concepts do not assume a simple natural 'fixing' of a product as an entity, which the actuality and metaphor of hybrid heterosexual reproduction might suggest. Instead, even a 'locked-in' material form may always change in its activity and significance, for instance by changing in its communicative meanings as experienced by the actors to which it is connected.

The elements in this hybrid assemblage are recognisably different, and move in relation to each other rather than in unison. However, the movement of elements is somewhat co-ordinated, as in

615. Hybridity frequently refers to mixtures of only two different things. Its duality seems to derive from its original use in heterosexual breeding of plants and animals. My concept of hybridity shifts from dual to multiple.

the activity of a flexible mechanism. For so long as the elements resist coalescing into a single package, this hybridity contains an aspect of inherent ambiguity and multi-partiality. If the system coalesces into a singularity, or stops activity, or separates into unattached entities, it is no longer hybrid. This is not an organising logic of aggregation, where basically similar elements become more active through greater mass. It is not a method of partnership, where elements are juxtaposed through their similarities then their differences explained away. Nor is it a technique of hierarchy, where differences are subsumed or remodelled into a singularity of purpose and method. For instance, an illegal syringe/user hybrid in 1986 was significantly different from a legal syringe/illegal user hybrid after the NEP began operations as a licit public health organisation in 1988.

The NEP's pharmacy-model boundaries could extend only with support from and dependence upon state agencies and state funding. Yet if not extended, any inadequacies in the NEP would be magnified in significance by the threat of HIV/AIDS, which would undermine the evidence-base and accountability of licit stakeholders, especially politicians. Such threats to well-established institutions might be shrugged off, but less so at a time of public urgency and potential panic, when trust in medical and official authority most required buttressing. Accordingly, the local illicit pharmacy boundaries coalesced with the boundaries of the World Health Organisation's global health model of community empowerment. Within these boundaries, the activities of moving syringes and somehow engaging with IDU became formally reshaped in a management plan and in a list of shop outlets. This activity of selecting and linking within a guiding set of boundaries, by a network of stakeholders, led to the consolidation into the NEP as a particular expression of a harm reduction institution. Once established as an entity, the NEP appeared within distinctive public boundaries. It acted as if following a career, with goals and chance affecting its course, while aligning its objects with people interested in maintaining its direction. Yet it also expressed a character which remains notably partial, multiple, and hybrid.

An intriguing hybrid presentation of some concepts of 'articulation with innovation' has been offered by Deleuze and Guattari in their mischievous appropriation of H.P Lovecraft (1991), Sir Arthur Conan Doyle (2005), and Foucault (1972) in a framework, or mode, of 'stratified meaning' as 'abominable history'.⁶¹⁶ In their techno-professional myth of origins:

An organism befalls the body of the smith, by virtue of a machine or machinic assemblage that stratifies it. "The shock of the hammer and the anvil broke his arms and legs at the elbows and knees, which until that moment he had not possessed. In this way he received the articulations specific to the new human form that was to spread across the earth, a form dedicated to work. ... His arm became folded with a view to work". (Deleuze & Guattari, 2004: 46-47)

Such joints were later presented at times as 'invisible hands' of markets, and 'invisible elbows'. Just as the hand has been associated with cunning agency rather than limited mobility, so the elbow

616. See *10,000 B.C.: The Geology of Morals (Who Does The Earth Think It Is?)* (Deleuze & Guattari, 2004: 44-82). *When the World Screamed* (Doyle, 2005), *At the Mountains of Madness* (Lovecraft, 1991).

has been associated with clumsiness, as in inadvertently knocking things over (Jacobs, 1991) due to its invisibility. Tilly (1996) drew attention to the role of elbows in the error corrections of repertoires of social action. Rather than valorise a structurally individualised model of a 'rational' though invisible hand (agency) coherently configuring the 'rational' market (brains and eyes), Tilly drew attention to clumsy recovery performances as locally individualised, skilled, socially-argumentative, yet inherently incomplete adaptive responses to interactive environments. Tilly linked claims about markets being self-planned and not needing to be accounted for due to 'invisible hands', to observations about how market exchanges are actually performed.⁶¹⁷

For Tilly, reason and reality link through mechanisms and interactional patterns that directly express a relational ontology. Tilly (1997a) rejects over-individualising and over-holising ontologies as unreal. He considers that reality becomes ontologically divided into micro-narrativised and macro-narrativised worlds by being presented as dependent on narrative, rather than employing narrative epistemologically to communicate knowledge about how structural mechanisms work. Since these worlds are not connected through evidence, he argues, their linkage through narrative alone causes 'headaches', aptly illustrating how the poor matching of systems of articulation and explanation creates the systemic and personal distress experienced in messy realities.

These metaphoric models of articulated mechanisms draw attention to the linkages between actual cycles of activity and the structures of expected motivation with capability, which together constitute my research focus on the NEP.⁶¹⁸ My approach shows actual antagonisms which hybridly connect to actual syringes in ways made more complex, yet also more intriguing and productive, by the disjointed narratives circulating and being translated across boundaries. Such considerations led to tracing the differences back and forwards through glacial movements in their organisational forms, to where those forms suddenly emerged or changed. The identification of such turning points provided starting and end points, as well as a set of critical institutional contexts for tracing the development of incidents forward as they became grouped and sequenced into narratively meaningful events. During this time I worked on identifying and selecting different activity and locality categories for the types of work done by the authors of archival documents, or those mentioned in such documents.

617. In terms of planning, the precision implied by the hand was over-rated, the scope and speed of the elbow was presented as more germane in practice, yet the invisibility of such elbowing was of a more intense degree than that of the hand, even though the hand would be disconnected, as a dangling appendage, were it not for the articulation inhering to the elbow.

618. Relationships of predator and prey between human, animals, and plants would form a prior cycle of articulatory innovation and a continuing source of meaning contributing to technological innovations. Relationships with unseen bacteria and viruses, such as HIV and HCV, transported through syringes and observed through testing technologies, would be formed in a later cycle, again dependent on uncertain performances within an existing structured repertoire. Extending such models of articulation leads to concepts of the zones and boundaries of performative action, which may thereby be positioned in relation to the zones and boundaries of scripts and repertoires.

In the NEP case, the institutional boundaries were not active apart from being experienced and expressed. They did not exist 'elsewhere' in a 'structural foundational' or 'predetermined attractor' sense, despite having a delineated articulation and location. The NEP mechanisms have been somewhat object-like, but are not machines as commonly understood since they have not merely followed a prior design. Nor are they simply living organisms where a pattern of a whole has been sketched out through genetic inheritance prior to an organism's biological separation from parents or predecessors. Because mechanisms have an articulated object nature as well as an adaptive, intelligent nature, they connect objects and institutions with nature and society. Such mechanisms may be non-human, or unconscious, or autopoietic,⁶¹⁹ as well as designed for implementing policy in programmes.

The NEP case emerged as far more hybrid than I initially conjectured. The turning point of the research involved the realisation that the systematic productivity of the NEP as a complex⁶²⁰ entity constituted the inverse of the systematic problems associated with the isolation and specialisation of the NEP peer personnel. Neither the productivity nor the problems could be considered a thing, or range of things, but instead were more usefully treated as effects. This led to identifying the links of a relational mechanism that could braid such a continuous, many-stranded effort through organised activity and agency. An uneasy, ambiguous, interlinking of differences articulated both the effort and effect which has characterised the NEP case.

The concept of hybridity resembles a collaboration of competing actors in an internally unstable alliance that is encouraged into stability due to external boundary constraints and strong motivations to produce⁶²¹ essential services with minimal structural organisation. The external boundary effects are simultaneously stabilised by means of the internal alliances. The co-production of both types of instability produces a dynamic stability for the whole system, which becomes expressed as a tenuous sustainability. This conceptual model explains how the NEP has been simultaneously stable and unstable, both solid and full of gaps, both shaped and shaping. In so doing the model engages with the way associations, collaborations, collusions, alliances,

619. After initially utilising the hybrid mechanism concept loosely, in order to grasp an overall sense of critical objects, legal boundaries, duration, cycles, and productivity of the NEP, I then extended the concept by drawing on writings on autopoiesis by Humberto Maturana and Francisco Varela, and Niklas Luhmann to explain the NEP's durability and self-maintaining aspects. However, I rejected overly 'strong' and overly universal systemic conceptualisations since I wished to utilise the benefits of a structural approach to objects while minimising the attendant harms of objectification, foundationalism, universalism, and functionalism. Accordingly, I emphasised the 'gadget' approach of a 'tool kit' by emphasising object-hood and variability in form, setting, inscription, and meaning. See Maturana (1999), Varela (1981a, 1981b), Varela, Maturana & Uribe (1974), Luhmann 1986a, 1986b, 1993, 1998, 2002). I consider that science and scientific analysis are matters of gadgets rather than theory, since science is done through gadgets, has a mark of institutional success and status by becoming the science of 'working devices', such as can openers and research programmes that can be commodified and sold to individuals and governments.

620. Much synchronic, non-longitudinal conventional sociology attempts to correlate quantitative relationships between assigned qualities, termed variables. Statistical modelling and quantitative sampling of the operationalised variables of such models determines the strength and relevance of the purported qualitative relationships. Abbott (2001) terms this the General Linear Model', and reviews it unfavourably for being unsuited to much research it is employed for.

621. Produce, not provide, since these services are not obtainable anywhere else.

partnerships and unions actually work, and are experienced by participants.

Collaborations between groups which pursue overlapping needs have been central to the health models produced and reaffirmed by the World Health Organisation, such as the *Alma Ata Declaration* and *Health for All* (Fear & Barnett, 2003: 5). A different though related aspect of this concept of hybridity involves a biological model. This model describes how external ‘varieties’, from an external categorising perspective, become genetically internalised in a single living system in which self-maintaining aspects of homeostasis and autopoiesis may be observed. I have entwined these biological concepts with systemic concepts of a dynamically networked, heterogeneity. By heterogeneous I mean that a single system, or interactional mechanism, includes different actors, such as viruses and syringes, drugs and ideologies, criminals and health organisations; and that the interactivities characterise the system, because of rather than in spite of the differences in the performance of effects. Moreover, the system, in maintaining its sustainability for a time, helps to keep these entity effects separated in terms of their understood boundaries. The system does this through its constant activity in linking sites into neighbourhoods of circulation. This hybridity is interpreted as partly collusive and partly competitive, with no clearly singular agents or objects or essential foundations in the web of actancy.

The NEP situation was intensely hybrid because in the very action of combination, raw differences were required by wider spread agencies and logics to become insulated by boundary lines and silences. In the process, adaptations were being worked out in sequences of occurrences, in repetitive cycles of innovatory events, expressed as synchronic structuring. The intensity, differences, and maintenance work required by the hybridity and commitment, in a situation of urgency, led to the NEP environment being problematic because it was productive, and vice-versa.

From a research perspective, the putative hybrid mechanisms needed to last long enough for their operations and products to be observable, but no longer, nor any deeper. They needed to be similar enough to other mechanisms to be recognisable by a researcher and later readers, but not identical. In actuality they involved iterative activity of periodicising flows from and to their environment. The development cycles showed that the patterns of interaction were sustainable and solid. These were ‘soft machines’ (Burroughs, 1992), distributed in their working across systems, focused on particular syringe-professional products that were packaged into the NEP locale. As the syringes and viruses entangled and overflowed, they organised and made coherent the resilience of obdurate materialities while producing chronologies from the intangible overflowing sequencing of temporal moments.⁶²²

622. Such mechanisms might be intelligent if feedback measurement-control loops created a self-referential type of operation. If boundaries were sufficiently important and maintained through the machinic operations along with informational interactions, I considered that a cybernetic organism had become active as a cyborg. Here I drew on Donna Haraway’s concepts and case studies of cyborg unpredictability and productivity (1991a, 1991b, 1997, 2000a, 2000b, 2000c).

Temporalities

The NEP case

Historical conceptions, such as discussed by Abbott (2001), involve categorising event sequences as largely stable and somewhat predictable 'trajectories', combined with far less stable and unpredictable 'turning points'. The concept of 'turning points' means that any and all 'past' occurrences need to be considered as if, in an analytical space, they are currently active as critical moments, as sources of explanations, and as continuing influences. However, some past events are more active, at any time, in particular networks and bounded locations of the present, than others.

Abbott (2001: 261) has suggested a more structural conceptualisation by asking if 'boundary lines of difference'⁶²³ might come first, and only later become consolidated and diversified in developmental forms of expansion, connection, differentiation, and strategic alignment (2001: 271). Such a concept joins provisional contingencies to durable patterns, without requiring a totalising schema. From this perspective, turning points can be explored by asking how a potentially viable change actually happened at a particular time and place, and with what means of shaping. I use turning points to help explain how occurrences and events become mutually constituting.

I combined Abbott's analysis of shifting professional boundaries with the actor-network analyses that by following and describing activity, lead to better understandings about expert authority, techniques of control, and hybrid articulations. I described how concepts of professional boundaries, along with legal boundaries, helped participants to define themselves as at least two distinct constituents, as peers and as quasi-professionals, which became contingently assembled and remained uneasily connected in the NEP. I showed how IDU were constituted from their resistance to being subjected to the treatment professions and to the medical control of drugs. In my analysis I combined these descriptions with concepts of boundaries to postulate the presence of hybrid stabilising mechanisms involving expertise, accountability, exclusiveness, and trust by NEP clients.

Social studies of scientific developments have shown the significance of the cultural contexts and goals of research (Shapin & Schaffer, 1985). Actor network methodologies have been highly successful in case studies dealing with the production of specialised knowledge and knowledge systems, especially biomedical expertise. In actor-network approaches, biological, biomedical and health knowledge is not only actual, but has also been constructed alongside the authority of expert systems and occupational roles to represent reality, by means of network effects.⁶²⁴

623. Abbott's boundary lines can be crossed, and effects emerge, due to effort and strategic agency (Abbott 2001: 271). Being both positively and interactionally inclined, Abbott is seen to be grappling for a more rigorous form of analysis which nevertheless is not determinist. Similar goals appear in actor-network methodology. Further research might read Abbott's boundaries across Deleuze's 'articulated breakages' (Deleuze & Guattari, 2004: 46-47).

‘Obligatory passage point’ is a classic military, political, and hunting mechanism used to describe the causal processes and integrate contingencies in actor-network methods.⁶²⁵ The NEP’s policy resisters, policy objects, and policy benders together implemented coupling arrangements between IDU and official networks through negotiations, syringe objects, and information exchanging practices (Murdoch, 1995: 752). Inasmuch as these couplings became sustainable hybrid arrangements, they became increasingly stable, eventually becoming obligatory passage points. Such passage points feature in the regular and mandatory movement of syringes and returns that support the expectations and durability of the NEP network. The actors who overcome resistance and successfully control obligatory passage points become ‘obligatory antagonists’ to other stakeholders, as seen in the peer-professional strike threat in 2001 which emerged from increasing peer control of information and peer influence over NEP funding.

Longer-term patterns of implementing syringe exchanges and regular services, if stabilised by obligatory passage points, seem likely to become formal occupations. Even if such occupations are demand-driven by client needs, any that are supply-directed are potential sites for professionalising, due to the mutual interests of a specialised and more easily organised collective of suppliers of syringes, services, funding, protocols, and permissions. Passage point mechanisms may act cybernetically if their informational products, such as trust expressions, ethical protocols, and health messages, alter the shapings that such events partly depend on, in a motivation-altering feedback loop. The opportunities and constraints of Abbott’s ‘lines of division’ connect to the obligatory passage points of actor-network approaches, in a flexible cybernetic mechanism leading to a professionalising of expertise as a contestable ethic and ethos.

I found cycles to be useful as a conceptual device that integrated my shorter-term interactionist and actor-network sensitivities with my longer-term sensitivities to chance trajectories, contingencies, and path-determinations. Cycles also allowed for a wider, event-focused framework than the more localised effect-focused environment associated with actor-network case studies. Actor-network type precautions about conceptual assumptions in advance of case exploration reduced certain risks of using cycles causally, rather than descriptively. These risks involved attributing unwarranted causal power to the phases and cycles that none of the participants themselves talked about. The NEP’s participants did however talk about effects constituted from interactional networks, though in a fragmented, dis-articulated way. I consider my re-articulation and partial integration to be warranted.

My event sequences, despite the partial, unfixed, and cross-linking aspects of my research, involved a ‘first exploration, memo-making during, heuristic last’ method. These are abductive sequencings suited to a following approach that might lead to inductive categorising. This is not an

624. See Latour (1999a, 1999c, 1988, 1987), Callon (1999), Gomart (2002a, 2002b), Gomart & Hennion (1999).

625. See Callon (1991, 1999), Callon et al. (1997), Latour (1988: 43).

approach founded upon a strict requirement for predictive falsifiability.⁶²⁶ Yet any counter-data or better explanations unrelated to a peer-professional mechanism would weaken the articulated coherence of my argument. The theoretical framing is both relativist and grounded. It is constructionist but not structural, nor subjectivist (Midgley, 2000: 124-128; Crotty (1998: 63). Nor does it claim universal scope and predictability. Yet because I have looked in empirical information for significant connections, represented such patterns in formal ways, and outlined causal sequences where these can be demonstrated, this research is evidence-based. It can be contradicted in its constituent parts, and alternatives can be produced to challenge its whole. It is both social science and narrative history, while not fitting dependently into either category alone.

My account of the NEP has engaged with the inductive problem of the policy emergences being less predictable than the events involving various linear relationships of causes and effect. A 'peer-professional' perspective seems somewhat relevant to any professionalising environment where secrecy and stigma are involved in the health outcomes. The NEP's peer-professional arrangements appear localised within a niche of specialised activity, carefully not noticed except by those required to pay attention. Yet the patterned IDU deviance that necessitates the NEP's institutional response to HIV/AIDS proffers analogies to other marginal life situations. The intensity of the differentials in the NEP environment highlight its case with dazzling camouflage, thereby illustrating a wider field.

Temporal Frameworks

I draw attention to the trinary melding of temporality, materiality, and information. Without temporal change, nothing is significant, and in all thermodynamic measurements it is observed that nothing evades change. Materialities are significant because their potential durability can slow temporal change and thereby explain durability or its absence in particular local cases. Information also constitutes reality in observer-dependent ways by being carried between or linking parts of temporal-material systems, as is measurable in the phenomena of quantum entanglement. The 'system background' pattern of information is directly communicative, and can also be modified to carry conversations, as seen in the way syringes 'converse knowledge' between IDU, peer-professionals, health professionals, police, and health officials.⁶²⁷ Temporalities, materialities and information cannot be ignored in the problematising of discontent and opportunity by policy actors,

626. The convincingness of a coherence-based scientific argument does not depend purely upon the falsifying of counter-hypotheses. Nor does a coherence-based scientific argument depend upon prior, universal foundations assumed to lie beyond the purview of observed experience. The type of social science I am doing is immanent, not transcendent.

627. I do not consider that information requires a specific observer, or a self-conscious observer, since cybernetic systems of cause and effect are both part of reality and a system of observational location. Feedback loops of form and force create the potential for self-control of a mechanism. Cybernetic systems carry information. But information does not have to be predictive. Its activity can be simply reactive and situated. Since information is inherently interactive, articulated across differences, perhaps types of information cannot exist except in being part of cybernetic systems.

or in explaining a policy intervention.

There are no satisfactory models of temporality, but some are worse than others. I use a 3D instead of a 4D model of space-time (Sattig, 2006) because I observe no persuasive evidence that objects ‘have’ temporal dimensions. Objects do not act as 4-dimensional things or effects that simply continue of their ‘own’ nature. Instead, I observe interactions and sequences of 3-dimensional objects, all slightly different, that follow each other. I am persuaded towards this model by the difficulties in determining the boundaries of a 4D object compared with its environment and with its internal constituents. Given these ambiguities, the 3D model seems simpler, involves fewer leaps of faith, and less complexity in articulating the temporal distinctions assumed to be involved.

I act as if temporal flows and dimensions are effects produced by hard-to-observe aspects of reality, combined with self-deceiving aspects of consciousness, along with narrative techniques that require and valorise a problematic ‘sense of flow’. The significance of this model is that identity does not continue in an essential manner, as if flowing through time. Instead, identity is assumed to be constructed at a particular moment by means of the interactions of whole environment, especially in the location where an object is active in expressing boundaries. This allows for somatic change and reflexive agency, against concepts of human nature being determinist.⁶²⁸ Nonetheless, I have assumed that the NEP’s participants used conventional models of temporal flow.

I use certain terms in specific senses. ‘Incident’ is a narrative commodification, a description of an aspect of reality, presented as if isolated and unique. By contrast, ‘event’ is the meaning of a pattern in a narrative sequence of incidents, as understood interactively by a dominant group or within an influential local environment. Events express form through the shape of their pattern. Events also express force by answering ‘why’ questions and helping to cohere individual motivations towards collective goals. In such projects, earlier ‘periods’ and ‘era’ act as durational cases that are bounded or made coherent by later actors. These durations embody both chronology⁶²⁹ and interpretation as everyday history. ‘Path-dependencies’ express how earlier events change the environments of constraints and opportunities that influence later decisions over long durations, not being limited to immediate causes and effects. This mechanism explains how forces can be exerted by events after all the initial actors are dead and their rationales forgotten, yet a trajectory of some sort continues, although without any temporal flow.

‘Trajectories’ describe a type of path-dependency involving relatively consistent, adaptive change. Trajectories are events presented narratively as if from the perspective of an object that moves sequentially within an environment that is assumed to be largely static, but sufficiently active to

628. For example, religiously in dogma over essential souls, genetically in concepts of race, or in the gender role determinism prevalent in evolutionary psychology.

629. ‘Chronology’ is the order of incidents, as mapped and enumerated in calendars and lists.

somewhat influence the object movement. The object has motivation to move due to some type of force, has inertia due to its form of durability and solidity, but has an shifting interface with the environment where changes in angle, speed, cohesion, and appearance may appear. Another form of path-dependency is found in cycles, understood as folding, iterating events, where change is more acute than adaptive, but not random, nor chaotically complex. In this NEP history I treat such ‘folds’ and ‘cycles’ as recurved trajectories where a similar pattern is triggered by contingencies, yet is notably path-dependent. The path-dependency, which describes how a single cause has multiple and repeating consequences, intersecting with the similarity of environmental features, together describe how the repeating pattern of folds and cycles came about. This situational history offers a model for other repeating and intermeshing patterns.⁶³⁰ For instance, when the NEP strike erupted in 2001, and when the police in 2004 reversed their previous commitment to support the further decriminalising of syringes, such models can be usefully questioned. These models of trajectories, stoppage, reversal, and cycles can assist in understanding differences in participant perspectives and enable many perspectives to be integrated as a single account.

The regular movements of objects and pseudo-objects can describe historical trajectories. The sudden shifts of object movements can both highlight and identify historical turning points. When regularities partially continue in changed form after a shift, it can be useful to explore (quirk and queer) the phenomena through the metaphor of cycles. The adaptive cyclic framework I have presented can be thought of as variations on a theme, involving structural repetition as well as narrative progression. A certain structure is offered, simultaneous with variations, adaptations and ad-hoc adjustments. It can never be repeated exactly as a living performance, but can retain influence beyond its once and only performance by becoming inscribed into material arrangements. Furthermore, the processes and mechanisms involved might be generalisable. The conceptual instrument of ‘a cycle’ is useful in research because it is a way of selecting or tuning one’s perceptions for recurrence. If cycles are found, there is an increased likelihood of there being a mechanism of some description at work.

Cycles have assisted in my appropriating previous conceptualisations of HIV/AIDS and HCV policy responses and adapting them to better fit the NEP situation. I explored my area and materials at hand first, then developed the cycles as a presentation device. This is not to say that such cycles are not ‘real’, but rather, that they are partial and do not encompass the whole case. They are a narrative device that translates aspects of a complex, recurring mechanism, and presents those aspects as a model framework (Tilly, 1997: 7-9). The indigestible mass of research material is

630. Reflection on these metaphors of folds and cycles emphasises how they are directionally different and similar. They differ in that a fold becomes angled into a stoppage and reversal, whereas a cycle rotates in the same direction, creating a sense of linear temporal progress. They are alike in being a form and a motion motivated by a force. They are topologically similar in a cycle being a ‘double fold’ that has been smoothed-out and extended or repeated, while a fold is a cycle squashed flat. By turning a folded pattern into a cyclic pattern, the stoppage and reversals inherent in messy realities become an invisible background to a singular event from a hindsight perspective.

thereby transformed into a more portable and accessible product. Provided the cycle metaphor, as a heuristic, does not contradict my body of material, it is acceptable for the less significant materials and themes to be left out (Tilly, 2002: xiii; Brown, 1999: 84). This allows me to focus on and identify a particular recurring mechanism by comparing similarities and differences between the cycles (McAdam et al., 2001: 30, 33). Instead of constructing consent, this mechanism constructs conflict. This is recurring because it is based on a sustainable environment, is triggered by success, and compelling reasons exist for participants to persevere.

My use of cycles⁶³¹ has been restricted to identifying types of events, not to accumulating or analysing an array of pre-defined events. The furthest I go in such a macro direction is to argue that during the NEP developments, large scale institutions of justice and health changed significantly in their structure. But they changed little in their associated professional aspirations, particularly in the defining and distinguishing of their jurisdictions of problems and expertise. Furthermore, social cycle theory suggests possibilities of a linear sequence of cycles, each separated by a reversal, or collapse of the growth aspect of the cyclic pattern. This possibility is theoretically relevant to my argument since the concept of 'AIDS exceptionalism' is effectively a relative brief single cycle from professional control to community control and back to professional control.⁶³² Yet the New Zealand peer-professional cycles have not collapsed.

In the peer-professional case there is a part-cycle of gay community organising, from grass-roots to peer-professional to corporate. This initial part-cycle split into staggered, parallel components of a pattern that repeated with the Prostitutes Collective and the NEP. Each community version of this pattern exhibited similar tendencies, yet each has been significantly modified by contingencies, as well as by the path-dependent aspects of the previous cyclic consolidations of policy and knowledge. These cycles are not presented as determining future events by constraining choices, nor even as describing such constraints on the resources needed to continue particular forms of social action. Instead, the alignment of variant sub-cycles is presented as a form of movement which indicates the presence of similar forces acting in a shared environment that contains

631. My use of historical cycles of micro-scale localised programmes needs to be clearly distinguished from social cycle theory of macro-scale processes involving socially large or total systems. See Rosenthal's (1958) translation of the *Kitab al Ibar of ibn Khaldun* (1380), Pareto's (1963) *Trattato di Sociologia Generale* from 1916, and Sorokin's *Society, Culture and Personality: Their Structure and Dynamics, a System of General Sociology* (1947); for seminal sociological work. See also Vico's (1984) *Principj di scienza nuova di Giambattista Vico d'intorno alla comune natura delle nazioni*, 3rd ed. from 1744, Postan's *Essays on Medieval Agriculture and General Problems of the Medieval Economy* (1973), and Braudel's *Capitalism and Material Life, 1400-1800* (1973) for classical historical or periodising analyses. My usage also is different from 'event sequence' and other historical methods that rely on mathematical modelling and may involve cycles. I make no attempt toward mathematical modelling, partly because I do not use large enough numbers of participants, or states, or variables, and the duration separating them is too indistinct. The detail I work with in narrative social history is too fine, individualising, and localising of meaning for the the large data-sets and universalising character of a mathematical model. Mathematical modelling seems possible if larger numbers of participants or NEP cases were studied. See Turchin, Grinin, Munck, & Korotayev (2007), Nefedov (2004), Blossfeld & Rohwer (2002), Chu & Lee (1994), Usher (1989). Nonetheless, it may detract and distract from the goals of sociology, as argued by Mills (1959: 71-75). Instead, I use a logical mechanism.

632. Repetitions of a cycle of exceptionalism would be expected in the case of new diseases which resisted cures and quarantine and were considered a major threat to the public.

contingent discontinuities and variation. As I use cycles, they are a research device to delineate and count the outcomes of alignments of forces that are actual, but otherwise too distributed, or discontinuous, or disguised, or not engaged with human sensory apparatus, to be easily visible. They focus on the topological ‘image’ aspect of a sociological ‘image’-ination (Mills, 1959), linking immediate troubles to historical issues.

Boundaries of various sorts have been established through codes of law and conventional expectations. Such boundaries were passed through and worked around in everyday practices. These boundaries were modified in urgency in the exceptional instance of the NEP but only in specific geographical and legislative sites. Boundary work, clearly, has been crucial in the actuality and our better understanding of the NEP.

History and sociology

History is clearly related to sociology by its focus on social change, its characterising of patterns of human interactivity, and its narrative methodologies, yet often presents a smooth, misleading account.⁶³³ My argument does not treat history as smoothly continuous flow, since ‘nothing’ is observed to flow and disjunctures are common. Actual incidents seem disconnected and discontinuous in a temporal sense, joined by strands of narrative, remembrance, categories, and particularly by the material durabilities of ecologies, landscape, architecture and technologies.

History is particular and periodised into a sequence of incidents exhibiting one direction, called the past, in which things once done cannot be undone. A thing once done is totally fixed, and transfers a portion of such durability to the path-dependent constraints on the options for later occurrences. But these transferrals begin abruptly then fade at greater or lesser rates rather than being pushed or pulled towards the end, or ends, of history. This sequence of incidents can be called the history of incidents, dates, and things, but it is not the history of events and objects. Events are always looking ‘back’ to the past, in a hind-sight perspective of interpretation and projection where

633. 19th century sociologists attempted to move their methods away from historical studies and re-institutionalise as a new social science discipline, using positivist methodologies to address topics of a politically and personally meaningful nature (Austrian & Farnsworth, 2007). Yet there are difficulties relating individual human experience of change to the size of modern data-sets where the meaning of change is calculated but not humanly experienced. See, for example Lloyd (2007). Sociological methodologies also struggle with historical durations within which the meaning of terms may change, yet such terms are used to document troubles, organise data-sets and underlie claims to statistical rigour assumed to be timeless. Several significant problems with the relevance and productivity of sociological methods involve historical types of difficulty (Abbott, 2000). History is somewhat different from sociology in its genres of writing, its data sources being preselected by fate and interested intermediary parties. Historians have frequently sought the turning points that distinguish periods, while sociologists often seek consistent patterns. Furthermore sociologists are trained to focus on the present, where information is messy but prevalent, whereas historians are encouraged to avoid large data-sets and work in the past. Perhaps closer to the uneasiness that at times is found between history and sociology is the attitude to self. Historians write in the self, or persona, of the researcher, but skilfully, whereas sociologists seem trained in the skills of disguising or writing the self out (Erikson, 1973). Although the linguistic turn in social sciences, together with ethnographic, phenomenological, and critical theories all resisted the writing out of the self from research, much sociology still presents an arcane language of abstraction, numericism, and methodological mysticism rather than the grounded resonance of people and things. History might be called ‘the world echoed in text. History alters the ordering of the actual world (logos) through human writing and science methods (-logy, as in socio-logy). Yet whereas a ‘foundational history’ replaces general

meanings are inscribed into chronological periods and the boundedness of material objects.

Historians account for a multitude of braided event sequences in a single ledger which opens and hinges on the current common concerns. Yet each consolidation into a singularity is also a particularisation, as the account becomes one of many, all equally evidence-based, yet all differing in coherency, elements, emphases and relevancy. Historians use selection, grouping, and categorising to bring an echo of the actual past into the actual present as a single account which seems to travel against the actual sequencing of life. Yet in such bringing, the historian must stop, must express discontinuity, in order to fold a living perspective into a perspective 'of life', a reverse perspective. Walter Benjamin has incorporated such concepts into a memorable image of western history:

this is how one pictures the angel of history. His face is turned to the past. Where we perceive a chain of events, he sees one single catastrophe which keeps piling wreckage upon wreckage and hurls it in front of his feet. (Benjamin, 1999: 249)

Benjamin's colleagues rebuked his redemptive emphasis on historical 'recovery' at later stages of a 'single event'. Horkheimer argued: "Past injustice has occurred and is done with. The slain really are slain ... the injustice, horror, and pain of the past are irreparable" (Wolin, 1994: xlix). Benjamin replied: "The corrective to this way of thinking lies in the conviction that history is not only a science but also a form of remembrance. What science has 'established' can be modified by remembrance" (ibid). Elsewhere Benjamin argued that: "There is no document of civilization that is not at the same time a document of barbarism" (1999: 248).⁶³⁴ These sensitivities to unfixed consequences of conflicts and decisions led Benjamin to encourage the reading of history 'against the grain', as I also do in part when evaluating formal NEP history.

Benjamin urged that later history be put aside to better understand how things had been earlier, since later events gathered together the politicised meanings imposed by the victors of struggles. I differ slightly, by utilising such shifts to gather material on how and why a policy changed. Yet Benjamin also denied that historical articulation represented how things had been: "The true picture of the past flits by ... seized only as an image ... every image of the past that is not recognized by the present as one of its own concerns threatens to disappear irretrievably (Benjamin, 1999: 247). My argument follows critical aspects of Benjamin's complex and ambiguous thought. For instance: "The concept of life is given its due only if everything that has a history of its own, and not merely the setting for history, is credited with life." (Benjamin, 1999: 72). This concept overlaps with anthropological and actor-network sensitivities to the activity and meaningfulness of material

knowledge, subsidiary histories reinforce such foundations by adding to the store of general knowledge. The arguments of Kuhn (1969) and Foucault (1980, 1970), following Bachelard (1984) suggest that 'foundational histories' and 'paradigms of scientific knowledge' are similar and overlapping, though differing in their stance on the internal conflicts and locality of historic periods of knowledge.

634. This history is like Schrödinger's cat, not an active agent nor solid except in interactional 'observation' (Schrödinger, 1935).

objects in patterns of movement.⁶³⁵

Benjamin's critical theory from his Nazi-era reflections on the shifts between the fragility and solidity of history writings seem relevant in later periods of modernity when drug users may be sacrificed to creeds of abstinence founded on a binary ideology of purity and contagion. Yet the NEP and its peer-professionalism offer a celebratory account and argument, differing from Benjamin's historical analysis of system-wide catastrophe. By contrast to a 'progressive destructuring' story, I trace how the NEP's stability and structure emerged from unfixed and ambiguous moments. The first moments involved key actors making commitments due to their reasonable expectations of the NEP's stability. Yet these early moments altered the institutional and policy landscape, setting the scene for later changes. The maintenance of stability emerged from the 'solid' productivity that engaged usefully with other areas of ecological and social systems. This productivity is observable in the everyday interactivities, where the forces that motivate actual historical change⁶³⁶ can be analysed through the movements of key objects and actor motivations. Any tendency to hide the actual movements of human bodies and text bodies, in actual sites such as houses, offices, and archives has been countered by my actor-network approach of even-handed symmetry and attention to material objects.

635. However I differ with Benjamin on his immediately following point: "In the final analysis, the range of life must be determined by history rather than by nature ... the philosopher's task consists in comprehending all of natural life through the more encompassing life of history" (ibid). First, I do not accept any 'final analysis'. All analyses that are observable and demonstrable are firmly in the messy middle of things. Second, this perspective privileges human-centredness for no justifiable reason. Certainly it is often more convenient and relevant to be human-centred, but at the start of any enquiry it is more precise and parsimonious to assume the symmetry of all factors. Third, I find some aspects of particular histories less persuasive than experiencing 'reality' as part of somatically embodied, non-narrative processes, though I refer to 'actual' rather than 'natural', and feel that what Benjamin understands by 'nature', and 'life' are distinctly ambiguous. Such issues, I suspect, lies at the heart of Horkheimer's criticism of Benjamin's so-called transcendentalist tendencies. Hanssen comments that Benjamin may have been emphasising an opposition to 'vitalist' theories that mystified 'natural life', while simultaneously affirming an interest in romantic understandings of texts becoming a form of life which, through successive translations, could reproduce (Hanssen, 2000: 33). Nonetheless, Wolin (1994: 85) points out that Benjamin followed Lukács in celebrating the fragmentary nature of the essay form as a means of forcefully rejecting the conventional western ideal of an all-encompassing, systemic approach. Benjamin's 'transcendence' is likely to be better understood as abstractive analysis, since Benjamin's character is forcefully immanent as well as redemptionist.

636. While I employ historical sensitivities and techniques, I also take pains to avoid the positivist aspects of history writing (Steedman, 2001: para 42) as much as the positivism of biomedical accounts. My standpoint is critical and grounded, which I interpret as events and structures emerging from an information-saturated material environment,

Risk

I utilised an actor-network type of approach of describing mechanisms to explain how a pattern of peer-professionalism involved the personal experiencing of trust, of activity by non-human viruses, and of the enscripting and logistics of syringes with drugs, amidst an institutional niche where crime and health worlds mixed. Mechanism and niche combined to outline the case as more hybrid, of longer duration, and more pervasive than the NEP had conventionally been described. Peer-professionalism described a unique occupation, but also a site of articulation wherein the NEP's unique productivity was maintained. Yet such a mechanism might conceivably not have existed. It was risky and localised rather than universal, and thereby focuses attention on exceptionalism rather than systemic normality.

An actor-network sensitivity to sites and stories of activity has offered a way of integrating the sequential and structural accounts I have offered. Such activity is found in the movements of objects and information, and in the strategic shapings, such as of meanings and expectations, whereby both physical place and understood space entwine to constitute a lived environment. This environment was threatened by viruses and has been termed a 'risk environment'. Yet risk is a statistical description of past harm, expressed as a probability. Risk is not an actual harm itself, nor a general likelihood of future harm, except as a projection of harms that have been measured in the different environment of the past.⁶³⁷ Prospects of future harm are hazards, not risks, because they cannot be measured and calculated accurately. Hazards can only be projected and turned into risks by assuming that the conditions of past calculation will continue to apply.

These aspects of harm, hazard and risk are important distinctions because 'risk' is a potent, politically-laden term. A so-called 'risk environment' points to conflicts over knowledge because future risk does not exist. Yet by drawing on the 'scientific' associations of risk statistics, claims may be made for one perspective to take priority over others. Risks are a form of information, yet according to some understandings, information is less representative, less valid, and less relevant if self-reported. Accordingly, risk information tends to be produced through the intrusive surveillance of inaccessible or resistant practices and people.

but is not positivist. A problem with much historical positivism is that its assumptions and absences cause it to privilege a foreground analysis of the history as an already constructed effect. The method of doing this evades drawing attention to the actual research context of the researcher in the process of writing. Such positivism seems biased in presenting history as a 'thing' in the past, instead of also presenting the material or other contextual aspects of the archives being worked at and in. Accordingly, I do not consider historical positivism to be an inappropriate methodology for a sociological analysis where greater reflexivity to researcher positioning and the consequences of framing narratives is called for. Not all history-writing is positivist, however. Some is sociological, and it becomes so by expressing concern for methodology and consequences, as in the histories by Thucydides (1994) and ibn Khaldun (1958). See Shanske (2007), Dewald (2005), Butterworth (2001), Shapin (1988), Abraham (1983), Munz (1977), Merton (1973, 1957). Some historical methods present contextless overviews as well as suffering from positivism.

637. To be precise and determinate, a risk calculation needs to be applied to known past events, as a description of what people at that time were experiencing in terms of the proportions of harm.

The concept of ‘environmental harm’ seems preferable, as a framework for service delivery, to ‘harmful practices’ and ‘groups vulnerable to harm’. This is because many aspects of harm from viral disease can be socially constructed into human environments, yet such social connections become invisible when harm and hazard are reduced to isolated categories such as ‘risk’ practices, and to particular, vulnerable ‘risk’ groups. For example, among other routes, HIV is easily transmitted through men having sex with men unsafely, yet not all such men identify as gay. Services that have focused predominantly on ‘gayness’ have bolstered the health and empowerment of gay communities. But such services have also covered up the more private sexual connections between those men who do not identify as gay. The actual environments of harm involve divisions and a contestability made more complex and rigid through undue reliance on ‘risk discourse’.

Projections of future risk necessarily assume that the future will be the same as the past, and accordingly, may reproduce some effects they assume. Yet the nature of epidemics is such that the reason they are so lethal, and create such exceptional responses in social systems, is that their activity differs from the past. They are new, or cyclic. They are not normal. Stable laws and medical treatments may be described in terms of risks, and discretionary decisions made by judges and doctors. Hazards, by contrast, are active in challenging and overturning such stability of knowable risk information, as has been shown in the NEP history. The NEP occupied new sites and spaces by creating a new occupation at a time when HIV/AIDS hazards were feared, yet research into secret IDU populations was not possible. Accordingly, there could be no calculation of risk, no system of risk management, only a mechanism of experimental, empirical monitoring.

As I have shown in the main text, the NEP that resulted, and especially the peer groups, enabled better access for research and the consequent calculations of risk. These activities ‘drew’ this field of health work in professional directions, at the same time as it was ‘pushed’ from the boundaries with professions. This health field was ‘grown’ through the career aspirations and the desires by IDU peers for more advantageous political positioning to lobby, using representational and human rights discourses, for better health care for IDU.

The problematisation of ‘future risk’ requires a temporally engaged and sensitive method of exploration, together with methods of exploring local institutional structures and organisations. This is because historical understandings and accounts set the framework for the policy decisions which create risk by attempting to reduce risk. If more persuasive histories encourage a greater reliance on predicting the future, significant risk is entailed, since with more confidence comes greater hubris, leading to more dire consequences when the larger and more authoritative plans fail (Scott, 1988).

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List of Archives

CASONZ	No single archive located. Material compiled from all other archives.
CIVDURG	Christchurch Intravenous Drug User Resource Group.
Department of Health	National Archives, Wellington.
DHDP/WIDE	Drugs and Health Development Project, Wellington.
DIVO	Dunedin Intravenous Organisation.
Ministry of Health**	Working file on the NEP, Wellington. Contains a small number of Department of Health documents
NCA	National Council on AIDS. Minutes supplied by NZPC, Wellington.
NECO*	Needle Exchange Consumer organisation, Christchurch.
NENZ	Needle Exchange New Zealand, Christchurch.
SSSC	Social Services Select Committee. Parliamentary Library, Wellington.

* (NECO emerged as an interim peer group between CIVDURG and DISC Trust management of the Christchurch needle exchange).

** This was supplied on request under the Official Information Act. It does not include some documents categorised as 'private' rather than 'public'

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Medical professional. Positions in the Ministry of Health. Department of Public Health, School of Medicine & Health Sciences, University of Otago, Wellington. Associate professor and senior lecturer. Was a special aide to Dr. Michael Bassett during 1987. The primary co-ordinator and architect-assembler of the NEP.

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Labour Member of Parliament from 1972 - 1975 and 1978 - 1990. Minister of Health in the Labour government from 1984 to 1987. A key initial promoter of the NEP. Supported the continuation of the neo-liberal state sector restructuring. Historian. Author.

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Department of Health official on the AIDS TaskForce during the early 1990s. An early administrator of the NEP. Founding Trustee of The Lesbian and Gay Archives of New Zealand (LAGANZ) Trust.

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NEP National Manager, NENZ co-ordinator, and NEST manager from 2002. Research co-ordinator liaising with Otago School of Medicine and Ministry of Health. Has experience working for the DISC Trust 1995-2002. Current member of National AIDS Council (refounded 2007).

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Founding co-ordinator of DIVO, the Dunedin peer group. Artisan.

Nimmo, Simon.

ADIO Manager from 1990 to 1995. NENZ, NEP co-ordinator from 1995 to 2002. Needle Exchange Services Trust (NEST) co-ordinator from 2001.

Reed, Anna.

Christchurch co-ordinator of the NZPC. Member of the Christchurch AIDS Co-ordinating Committee since 1990. Recognised in the High Court as an expert witness on sexwork.

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DIVO Office manager and one of the two co-ordinators during 2003-2004.

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Press secretary to the Minister of Health Dr Michael Bassett during 1987. Journalist. Author.